An Asset-Based Indicator Framework: Using Co-Production, Co-Design and Innovative Methods to engage with BME Groups

AN ASSET-BASED INDICATOR FRAMEWORK: USING CO-PRODUCTION, CO-DESIGN AND INNOVATIVE METHODS TO ENGAGE WITH BME GROUPS

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‘*It is now time to stop fretting about how difficult it is [to evaluate asset-based approaches] and start developing innovative solutions’ (Morgan et al. 2010).*

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Project Overview

This report presents the development and first application of an evidence-based, co-produced methodological framework – an Asset-Based Indicator Framework (ABIF) – to "measure" changes in health, wellbeing and inequalities through creative community engagement.

If used systematically and continuously, the ABIF serves as a mechanism:

- for capturing "softer" outcomes inherent in asset-based working (such as trust and empathy) alongside traditional quantitative targets and measures.
- to link these targets and measures to local, national and international targets and outcomes.
- for evidencing changes (if any) in health, wellbeing and equity linked to asset-based work over time.
- for monitoring the effectiveness of asset-based work to engage service users and co-produce services.
- which can be used across topics and services (Health & Social Care Partnership and other partners) to monitor and account for asset-based activity.

The report is presented in two parts. Part 1 presents the findings of a critical literature review conducted to provide a foundation for the development of ABIF by:

- defining the underpinning concepts of asset-based approaches in the academic and grey literature to inform framework indicators.
- identifying and analysing the main methods used by researchers and practitioners to evaluate asset-based approaches.

Findings subsequently lead to the development of an evidence-based template for an ABIF, which is piloted and presented in Part 2.

Part 2 outlines the processes involved in co-producing and applying the ABIF in particular community settings with various partners by systematically working through its inaugural application with the Roma population in Glasgow's South Side; health practitioners at operational and management levels; academics; and third sector representatives.

PART 1

1. Background

Asset-based working is established on the model of "salutogenesis", which considers the importance of working with the capacities and resources that people already have (Foot and Hopkins 2010; Foot 2012; Hopkins et al. 2015). In contrast to deficit models which explore the *needs* of community, asset-based approaches seek to create conditions for health by strengthening the *assets* of individuals and communities (Morgan and Ziglio 2007). Here assets are defined as any factors or resources which have an impact on maintaining and sustaining health and wellbeing on individual, community and structural levels (Hopkins et al. 2015)

There is widespread policy support for the use of bottom-up, asset-based approaches as a potential way to tackle inequalities and co-produce services to improve community health and wellbeing. The idea is to work *with* community members to facilitate rather than delivering services *to* them (see Chief Medical Officer 2009; NHS Health Scotland 2011; SCDC 2011; Morgan and Ziglio 2007; Burns 2013; Hopkins et al. 2015).

Despite growing support for the use of asset-based approaches in community work, however, there is limited published evidence evaluating the working mechanisms of asset-based initiatives. Furthermore, concepts such as improved wellbeing, social capital or resilience, which are considered to be central to asset-based approaches, cannot be measured directly or tangibly which causes further difficulties in the evaluation of these interventions (de Andrade 2014; de Andrade 2016; Miller 2011).

2. Literature Review

A critical literature review of the academic and grey literature was therefore conducted to provide a foundation for the development of the ABIF. It sought to:

- define underpinning concepts of asset-based approaches to inform framework indicators.
- identify and critically analyse key methods used by researchers and practitioners to evaluate asset-based approaches.

2.1. Method

The initial search of the academic literature was conducted by screening texts in the following electronic databases: AMED; Global Health; OvidMEDLINE; PsychINFO; Embase; SAGE Journals online; Tailor & Francis Online; and JSTORE. In addition, several online journals were searched for relevant articles: *Journal of Community Research & Engagement; International Journal of Health Promotion & Education; Social Science; and Journal of Epidemiology & Community Health.* Finally, Google scholar was searched for academic literature.

A search in the grey literature identified conference presentations, reports and papers through general internet searches, as well as targeted searches of following websites: *The Organisation for Economic Co-operation and Development*; *Governance International*; *Understanding Glasgow* (*The Glasgow Indicators Project*); *Meaningful and Measurable* (*Personal Outcomes: A Collaborative Action Research Project*). A manual search of reference lists from included studies was also conducted to identify additional key publications.

The review only included studies published in English due to the lack of feasibility for translation of texts. The search of the literature was not restricted geographically.

The search strategy was divided into two categories. The first included broad terms related to the use and evaluation of asset-based approaches in health and wellbeing:

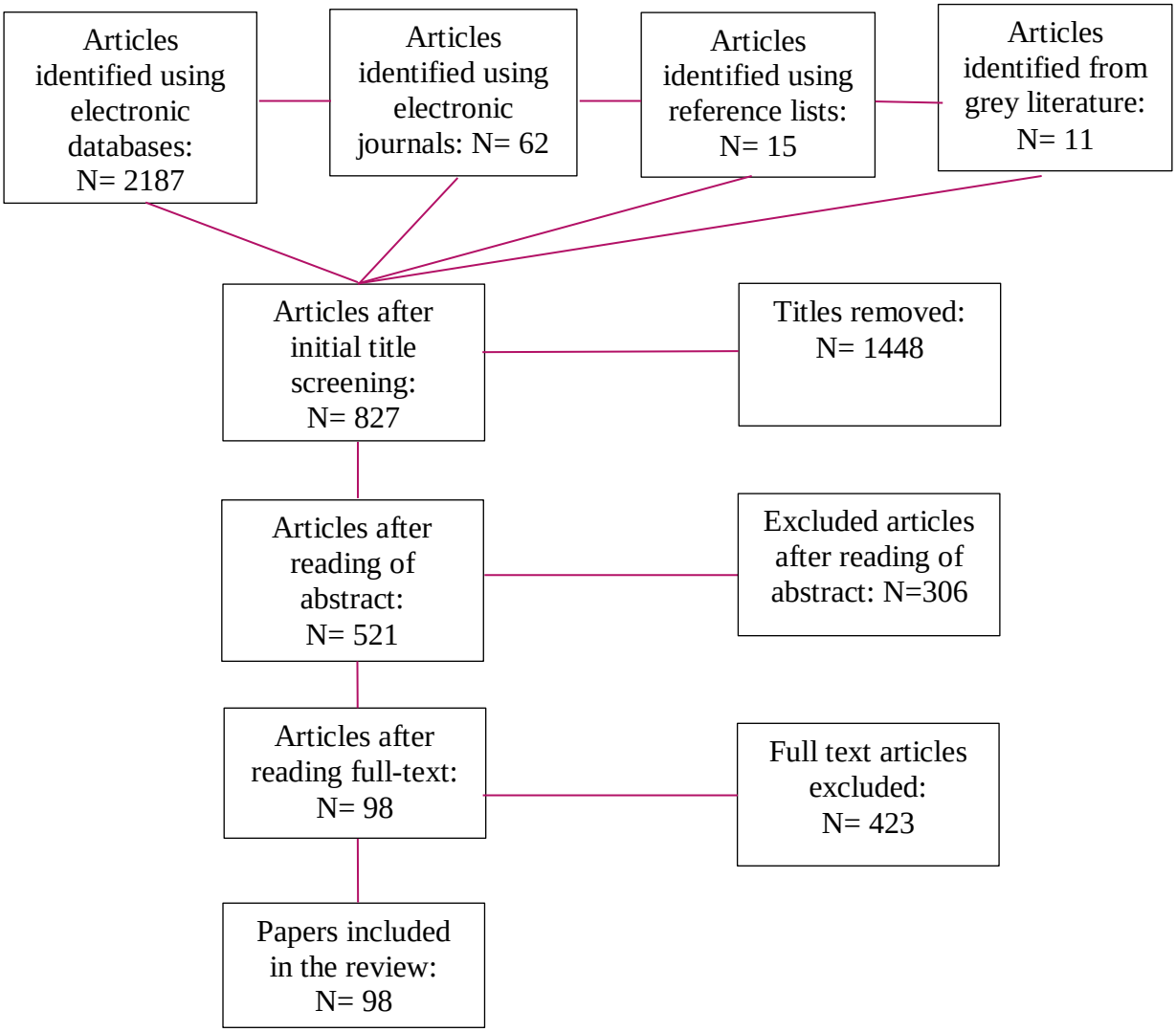
- 'asset-based approach*' AND ('effectiveness' OR 'evaluation' OR 'measurement')
- 'asset-based approach*' AND ('health' OR 'wellbeing') AND evaluation
- 'co-production' AND ('effectiveness' OR 'evaluation' OR 'measurement')
- 'co-production' AND ('health' OR 'wellbeing') AND evaluation

A further search identified terms related to asset-based approaches to inform framework indicators:

- 'wellbeing' AND 'measurement' AND 'public health'
- 'social capital' AND ('measurement' AND 'public health') OR ('wellbeing')
- 'resilience' AND ('measurement' AND 'public health') OR ('wellbeing')
- 'self-determination' AND ('health' AND 'wellbeing') OR ('measurement')
- 'trust' AND ('health' AND 'wellbeing') OR ('measurement')

- ‘affect’ AND (‘health’ AND ‘wellbeing’) OR (‘measurement’)
- ‘interpersonal relationships’ AND (‘health’ AND ‘wellbeing’) OR (‘measurement’)
- ‘self-esteem’ AND (‘health’ AND ‘wellbeing’) OR (‘measurement’)
- ‘social coherence’ AND (‘health’ AND ‘wellbeing’) OR (‘measurement’)
- ‘culture’ AND ‘public health’
- ‘empathy’ AND (‘health’ AND ‘wellbeing’) OR (‘measurement’)
- ‘spirituality’ AND (‘health’ AND ‘wellbeing’) OR (‘measurement’)
- ‘optimism’ AND (‘health’ AND ‘wellbeing’) OR (‘measurement’)
- ‘access to resources’ AND (‘health’ AND ‘wellbeing’) OR (‘measurement’)
- ‘physical health’ AND (‘health’ AND ‘wellbeing’) OR (‘measurement’)

The flow diagram below shows the number of publications initially identified, and those included following a screening for eligibility.



2.2. Findings

The review identified several indicators for the ABIF connected to *three key, overlapping concepts* used in asset-based and co-production interventions: i) wellbeing ii) social capital iii) resilience. A critical analysis of the literature led to the conceptualisation of these three interrelated terms in relation to individual, community and structural level influences.

i) Wellbeing

One of the main goals of asset-based approaches is related to the identification of protective factors that support health and wellbeing (McLean 2012). Wellbeing therefore plays a significant role in asset-based theory and practice, and is broadly defined and referred to at both individual and community levels. The literature identifies the challenges of defining wellbeing mainly related to its multi-dimensional and complex nature (Pollard and Lee 2003). This, in turn, causes difficulties in the measurement of wellbeing (Dodge et al. 2012).

Two main approaches, however, have emerged in relation to the study of wellbeing. The *hedonic tradition* understands wellbeing as related to constructs such as happiness; positive affect (the experience of feeling or emotion); reduced negative affect; and life satisfaction, while the *eudaimonic tradition* highlights the positive psychological functioning and human development (Dodge et al. 2012; Ryff et al. 2002). These theoretical perspectives have led to the establishment of two basic definitions of wellbeing: *subjective* and *psychological* wellbeing (Cloninger & Zohar, 2011; Keyes et al., 2002; Keyes, 2006; Ribeiro et al., 2011; OECD, 2013).

Subjective Wellbeing

The term subjective wellbeing (SWB) refers to the individuals' evaluation of the **quality of their lives** (Keyes 2006; OECD 2013). A recent systematic review on measurement scales of SWB identified six domains which have been referred most frequently by researchers as factors influencing SWB: **affect; social relations; life satisfaction; physical health; meaning/achievement in life;** and **spirituality** (Lindert et al. 2015). Several studies refer to the trichotomous structure of subjective wellbeing which consists of life satisfaction, positive affect and negative affect (Ashleigh et al. 2012; Lindert et al. 2015; Ryff et al. 2002)**.**

The subjective experience of pleasure and happiness by an individual related to experience of positive affect and reduced levels of negative affect lead to improved life satisfaction

(Cloninger and Zohar 2011). The subjective perception of quality of life is usually determined by following factors: **individual factors and personality, cognitive schemes (e.g. self-control, self-esteem, and optimism),** and **experience of the outside world (social support)** (Dodge et al. 2012)**.**

There is also a eudaimonic aspect of subjective wellbeing which links the individuals' perceptions of their satisfaction with **life purpose, social integration, personal growth, social contribution** and **autonomy** (Keyes, 2006). However, SWB is not only dependent on the subjective experience of individuals and their judgement of life but also has an objective characteristic which is related to external factors, such as **wealth or income** and the **healthiness of local environment** (Lindert et al. 2015).

Although some of the above mentioned factors influencing SWB might be relevant across cultures, a recognition of the relationship between the different components of SWB is essential to provide culturally sensitive evaluations (Lindert et al. 2015). Evidence suggests that pathways to wellbeing are different across cultures and, therefore, depend on the internalised cultural values (Diener et al. 2003). In individualistic societies, for example, the experience of improved wellbeing is related to achieved goals for fun and enjoyment, whereas in collectivistic cultures positive changes in wellbeing are associated with achieved goals to make others happy (Diener et al. 2003).

Further efforts to conceptualise SWB have been made by Headey and Wearing (1991), who developed the **"equilibrium model"** stating that SWB is fairly stable and can only change because of external influences. It has been argued further that each individual has a stable stock (consisting of social background, personality and social networks) which leads to the development of an equilibrium of subjective wellbeing (Headey & Wearing, 1991). Furthermore, individuals can deal with negative life events using their stocks.

This theory was later developed by Cummins (2010), who stated that wellbeing is centred on a balance that can be effected by challenges. A more recent multidisciplinary review of the different definitions of wellbeing concludes that stable wellbeing is possible only when individuals have enough resources to meet psychological, social, and physical life challenges (Dodge et al. 2012).

Psychological Wellbeing

The literature review identified a second tradition in the research of wellbeing, which refers to psychological wellbeing (PWB). The multidimensional model developed by Ryff in 1989 continues to be cited in contemporary conceptualities of psychological wellbeing (Keyes 2006; Ryff et al. 2002; Ribeiro et al. 2011)

Ryff (1989) identified five aspects of psychological wellbeing**: self-acceptance, interpersonal relationships, environmental mastery (shaping your environment to meet personal needs), self-determination** and **autonomy.** A sixth dimension has since been added, namely **purpose in life** (Dodge et al. 2012). A more recent conceptualisation of psychological wellbeing is the understanding that life satisfaction emerges from meaningful values and goals, which are related to the character development (Cloninger and Zohar 2011). A relationship between PSW and the Big Five personality dimensions (neuroticism, extraversion, introversion, conscientiousness and openness to experiences) has also been explored (Ryff et al. 2002).

A study on the impact of personality on different aspects of wellbeing showed that self-directedness (the ability to regulate and adapt your behaviour to the demands of a situation to achieve personally chosen goals and values), cooperativeness and self-transcendence (overcoming the limits of the individual self and its desires in spiritual contemplation and realisation) contribute to improved health and wellbeing (Cloninger and Zohar 2011). The strongest impact on the regulation of hopes and desires, which respectively influences wellbeing, was found to be **self-directedness associated with self-confidence**. Cooperativeness, which was measured by people's **social tolerance, empathy** and **helpfulness**, showed weak contribution to wellbeing if self-directedness was low. The authors concluded further that people with higher **self-transcendence** are more likely to experience high levels of life expectation. The limitation of the study is that it is a cross-sectional analysis and, therefore, does represent only an association but no causation between the variables.

Subjective vs. Psychological Wellbeing

The literature review identified only one study which looked into how the two conceptualisations of wellbeing differ from and complement one another (Ryff et al., 2002). Using a national sample of U.S. adults and valid wellbeing measures from both traditions, Ryff et al. (2002) concluded that SWB and PWB represent two related but at the same time

distinct conceptions of wellbeing. The authors suggested that when SWB and PWB exist at equivalent levels they might complement each other by creating self-congruency (consistency between the ideal self and the actual self). However, both concepts are complementary even if they are not at equal levels. For example, high SWB may help sustain a certain level of happiness when PWB is not possible due to a lack of opportunities, lack of resources or compromised health and vitality.

ii) Social Capital

The first definition of social capital goes back to Durkheim's conceptualisation of the phenomenon as a form of connectedness between individuals living in a community (Harper 2001). This definition was further expanded by Coleman (1988 as cited in Harper, 2011), who argued that social capital refers to obligations and expectations based on trustful relationships between individuals; the flow of information through social structures; and the existence of norms in a society. A more recent theoretical definition refers to social capital as the **norms**, **social networks** and **trust** in a community, which contribute to pursuing mutual objectives (Harper 2001; Putnam 2001).

Social capital is widely cited as a concept related to promoting wellbeing (Welsh and Berry 2009; McPherson et al. 2013; Gilbert et al. 2013; Murayama et al. 2012; Hills 2010; Cattell 2001). Indeed, one of the main aims of asset-based working is to support the development of wellbeing by building social capital in communities (Foot and Hopkins 2010). According to the literature, **increased connectedness** and **coherent social networks** contribute to the improvement of health and wellbeing (Foot 2012; Putnam 2001; Cattell 2001; Welsh and Berry 2009). Furthermore, protective health factors related to the development of social capital are **increased confidence and self-esteem, a sense of connectedness,** and **ability to bring about change in individuals' own life** (Foot 2012)**.** Participation in social networks is further related to enhanced sense of achievement and perception of control, as well as enjoyment of life (Cattell 2001)**.**

There are two distinct conceptualisations of social capital. The first, related to social cohesion, highlights the group attributes of social capital that influence individual health. The second views social capital as resources embedded within social networks that are individuals' properties (Murayama et al. 2012).

Social capital has also been classified into sub-categories: cognitive, structural, bonding, bridging and linking (Welsh and Berry 2009; Murayama et al. 2012; Putnam 2001). Cognitive social capital is understood as people's subjective perceptions of the **level of interpersonal trust, sharing,** and **reciprocity**, whereas structural social capital looks at external aspects such as **density of social connections** or **civic engagement** (Putnam 2001).

The most common distinction of social capital is the differentiation between bridging, bonding and linking (Welsh and Berry 2009; Harper 2001; Putnam 2001). Bonding capital refers to relationships based upon strong ties that connect homogeneous groups (such as families, neighbours and close friends). Bridging capital is relations between people who are from different ethnic or occupational background (such as colleagues, acquaintances and people from different communities). Finally, linking social capital describes connections between people with different levels of power and status. These relations are important for achieving strategic outcomes and increasing individuals' and communities' ability to influence change (Harper 2001).

The distinction between the different forms of social capital is crucial in understanding how social capital relates to the promotion of health of individuals (Kawachi 2006). Furthermore, it is essential for researchers and practitioners to identify which relationships (homogeneous or heterogeneous; strong or weak) are related to the increase of social capital and respectively to the improvement of health and wellbeing in a particular community (Kawachi 2006).

Bonding social capital, which is based on the trust in family, neighbourhood and friends, can lead to a positive increase in social capital by providing practical support and by benefiting from shared identities (Cattell 2001). However, several studies show that bridging social capital in disadvantaged, minority communities promotes improvement in health and wellbeing, whereas bonding social capital is associated with detriment to the health of residents (Harper 2001). This is due to the fact that strong bonding ties in disadvantaged communities are associated with higher expectations to assist others in need, which in itself is connected to higher levels of financial and mental strain. If the coping resources and mechanisms afforded by the social network are dysfunctional or lacking then the homogeneous networks might provide a limited support (Cattell 2001).

On the contrary, trust in wide networks (bridging social capital) provides an opportunity for individuals to access resources outside their social networks which might lead to the formation of social capital and the improvement of health (Cattell 2001; Kawachi 2006). The combination of different patterns of networks (homogeneous and heterogeneous, 'thick' or

'thin' forms of trust) related to increased access to the range of resources may therefore contribute to the development of a better quality of life and wellbeing.

It is important to note that the literature does not refer to the mechanisms by which high levels of social capital in a community can improve the wellbeing of individuals. For the development of the ABIF, it is crucial to explore connections between different forms of social capital and wellbeing and whether and/or how these relationships may vary in diverse communities and under different circumstances.

iii) Resilience

Resilience is associated with the theory of "salutogenesis" focusing on factors that support health and wellbeing rather than those that cause disease, which is central to asset-based approaches (Sigerson and Gruer 2011). Resilience has been conceptualised as an asset which contributes to the improvement of wellbeing and is often referred to as "sense of coherence" (SOC) – people's views about their lives and their ability to manage the demands of life and sustain good levels of health (Hopkins et al. 2015; Sigerson and Gruer 2011; Eriksson and Lindström 2006).

The concept's broad definition has evolved over time and been applied to different disciplines, but in general terms resilience describes the **adaptation of the character, culture, social practices** and **decision making in a community when it faces extreme situations** (Alexander 2013)**.** Moreover, resilience can be seen both as a dynamic adaptation in the context of danger and adversity, as well as a static ability to resist the danger (Alexander 2013; Lewis 2005).

The literature provides evidence of different interrelated factors which can have an impact on the capacity of resilience in the face of natural hazards; varying from time to time and context to context. One framework developed to address the resilience of traditional societies when facing natural threats considers four influential factors: the nature of hazards; intrinsic social conditions of a community; the setting in which the hazard has happened; and the external support provided to the group (for example, governmental policies) (Weichselgartner and Kelman 2015).

For the development of the ABIF, it is necessary to carefully examine the conceptualisation of the phenomenon "resilience". One of the obvious factors which can impact the capacity of resilience of traditional societies is the magnitude and temporal spacing of the threat. The

bigger the disaster, the more difficult it becomes for communities to resist and adapt after the experience. A further important factor influencing the capacity of resilience is the pre-disaster level of acculturation (the process of cultural change and psychological change resulting from meetings between cultures), and the cultural attachment to the devastated site (Weichselgartner and Kelman 2015).

It has been argued that traditional societies are the most vulnerable to cultural change. In cases where traditional societies had regular pre-disaster contacts with outside communities, they were able to maintain these relationships after the danger and preserve their social structure. Social capital (in particular bonding and bridging) and the capacity of resilience can therefore be conceived as interrelated concepts that influence the wellbeing of communities. Indeed, there is evidence to suggest that connectedness to adults and peers is associated with higher levels of resilience which respectively improves health and wellbeing (Stewart et al. 2004). In addition, rehabilitation policies set up by governments can influence the capacity of resilience of traditional societies. Importantly, the intrusion of policies without the acknowledgement of cultural specifications of a community might lead to high levels of cultural change and low capacity for resilience (Stewart et al. 2004).

Current evidence on asset-based approaches focuses on resilience factors that moderate risk responses *before* the occurrence of danger (The Young Foundation 2010). In this respect, resilience is perceived as an asset contributing to the improvement of health and wellbeing (Foot 2012; Hopkins et al. 2015). Resilience also has a mediating effect on the relationship between positive affect and physical health, as well as positive affect and psychological wellbeing (Nath and Pradhan 2012). The relationship between resilience and wellbeing, however, is not linear but influenced by different factors on the individual, family and community level (The Young Foundation 2010; Distelberg et al. 2015; Nath and Pradhan 2012).

In general, resilience is related to four main concepts on an individual level: **internal locus of control** (the belief that you can influence events and their outcomes); **self-efficacy** (the belief in your ability to succeed in specific situations or complete a task); **beliefs**; and **access to resources**. Finally, considerable attention should be paid to the **access to resources** when the capacity of resilience is researched on an individual level (Distelberg et al. 2015).

Further factors impacting the development of resilience in communities are **interpersonal relationships** with family and neighbourhood. Individuals who feel connected to family; feel safe and supported in their neighbourhood; and contribute and collaborate to the community

in which they live are prone to be more resilient than others (Cook and Miller 2012; Hopkins et al. 2015; Distelberg et al. 2015; Stewart 2014; Seaman et al. 2014).

Resilience is promoted when **long-term social relationships** are sustained, and this respectively protects health and wellbeing of individuals (Foot 2012). Research on asset-based approaches calls for consideration of methods to help individuals develop, support and sustain meaningful social relationships.

The first part of the review examined the *three, key overlapping concepts* related to asset-based working – wellbeing, social capital and resilience – in order to identify assets and attributes that could potentially contribute to improvement of health and wellbeing and reduction of health inequalities. These will inform ABIF indicators.
The literature on asset-based approaches suggests that if professionals work with individual and community *assets* instead of focusing on societal *needs*, they will deliver services that improve wellbeing, social capital and resilience of communities. These concepts theoretically describe different phenomena, but upon closer inspection, are interrelated and influenced by the same or similar individual, community and structural assets. The review found that individuals' wellbeing, for example, is influenced by the levels of social capital in a community. Furthermore, individuals' participation in social networks has been positively associated with life satisfaction and enjoyment of life. Additionally, resilience was found to impact wellbeing through personal characteristics of individuals, values and beliefs of communities, as well as interpersonal relationships with family, friends and the community.

These findings suggest that the three concepts are strongly interrelated and that understanding the granularity of their interrelations at individual, community and structural levels plays a significant role in the evaluation of asset-based approaches.

In order to develop an ABIF to "measure" changes in health, wellbeing and inequalities through creative community engagement, it is therefore necessary to map interrelated conceptual assets and attributes to see how they overlap. Table 1 clearly shows how wellbeing, social capital and resilience are influenced by similar or sometimes overlapping assets or factors – despite the use of different terminologies in the literature. The literature on wellbeing, for example, mentions self-control, self-acceptance, self-determination, self-directedness, self-esteem as impact factors; whereas the literature on social capital refers to confidence, ability to bring change and self-esteem. The literature on resilience uses

terminology such as locus of control, self-efficacy and sense of coherence. A further literature review found all the above-mentioned factors to be overlapping and, moreover, characteristics of self-determination (Posadzki and Glass 2009). It can therefore be argued that wellbeing, social capital and resilience are influenced by the same cognitive schemas. A more refined review of these assets is presented in the next section.

Table 1 Assets impacting wellbeing, social capital and resilience

	Wellbeing		Social Capital	Resilience
	Subjective	**Psychological**	**Bonding, Bridging, Linking**	
Individual assets	• positive and negative affect • physical health • meaning/achievment in life • life purpose • spirituality • personality • cognitive schemes (e.g. self-control, self-esteem, and optimism)	• life purpose • Big five personality dimensions • self-acceptance • environmental mastery • self-determination • self-directedness • autonomy	• ability to bring change • confidence • self-esteem	• locus of control • self-efficacy • sense of coherence

	• autonomy • personal growth	• social tolerance • empathy & helpfulness	• trust • sharing • reciprocity	
Community assets	• cultural values • social relations • social support • social integration • social contribution	Social relationships	Social connections (bonding, bridging, linking)	• acculturation • connectedness • interpersonal relationships (family, neighbours)
Structural assets	• wealth or income • healthiness of local environment		• access to resources • civic engagement	• access to resources

3. ABIF Indicators

An extended review of the literature on the factors and assets presented in *Table 1* was conducted to identify and define overlaps between definitions, and to establish the perimeters of framework indicators. This section presents the main indicators in the evidence-base, which will serve as the foundation for a co-produced ABIF. *Table 2* serves as an illustration of how each indicator might have an impact on the individual, community and structural level.

Table 2 ABIF Indicators

Indicator	Definition	Individual Level	Community Level	Structural Level
Affect	The experience of positive or negative emotions at a certain point in time (OECD 2013).	Individuals experience high average levels of positive affect which benefit their interpersonal relationships, creativity, sociability and productivity. Individuals are able to restore autonomic (unconscious or involuntary responses) after the experience of adverse negative affect.	Communities are engaged, active, creative, and connected through enjoyable social networks.	Individuals and communities respond to detrimental occurrences in the macro environment that negatively influence their health and wellbeing in creative and constructive ways (for example, human rights campaigning). Individuals and communities are fuelled by unfavourable environments. They adapt and respond to disadvantageous

				conditions in bold, assertive and goal-oriented ways.
Access to Resources & Healthiness of Environments	Resources needed by people to build and sustain their livelihoods.	Individuals have access to health promoting amenities and resources, which enable them to maintain healthy dietary habits and physical activity. Individuals have access to local organisations providing them with opportunities to access different forms of social capital.	Communities have sustainable health promoting amnesties and resources. Communities provide opportunities for individuals to access different organisations and social structures.	The state ensures that socio-economic distribution of neighbourhood resources is equal for each community. Co-production between local and external organisations to facilitate exchange and sharing of resources. Communities have the opportunity and capacity to influence rural planning and built environment decisions.
Culture	Knowledge, beliefs, values and systems of symbolic meaning that individuals draw on in everyday life (Spencer-Oatey 2012).	Individuals have a sense of identity and culture. Individuals are free to express and live according to their	Communities have opportunities for cultural recreation, the celebration of cultural values and differences.	Individuals and communities feel free to exercise their culture in an environment that encourages equity and respect for human rights.

		cultural values and norms.	Communities have the opportunity to engage with culturally specific health and wellbeing services.	
Empathy & Helpfulness	Empathy refers to the ability of individuals to perceive and be sensitive to the emotional experiences of others, as well as being motivated to care for their wellbeing (Decety 2015).	Individuals can sense and respond to the emotional experiences of others. Individuals are compelled to act and care for others when they feel it is necessary to do so.	Community members are interdependent, experiencing high levels of empathy and helpfulness. Cooperation and low levels of conflict between community members. Community members work towards the benefit of the group rather than individualistic goals when deemed to be necessary.	An understanding and enactment of the various factors that influence the ability to empathise. These include motivational forces (the need to belong, situational cues (attraction), individual or group differences (such as gender and ethnicity), levels of education, self-monitoring and awareness, culture and relationship-specific factors (Sherman et al 2015).
Interpersonal Relationships	Interpersonal relationships can be: - Bonding (based upon strong ties that connect homogeneous groups).	Individuals are able to benefit from functional aspects of interpersonal relationships such as emotional support,	Difference within and outside of the community group are acknowledged and	Communities recognise the principles of equality and social justice. Different community

	- Bridging capital (between people who are from different ethnic or occupational backgrounds). - Linking (between people with different levels of power and status).	companionship and advice in experiences of adverse stress. Individuals can sustain a combination of different types of relationships. Individuals are involved in community activities that contribute to the improvement of their health and wellbeing.	accepted. Communities provide widespread opportunities for informal contacts and support networks. Community organisations work with wider networks to mutual advantage.	groups, forums and organisations participate in voluntary sector events and initiatives.
Optimism	Expectations about the occurrence of good outcomes in one's future (Pinquart et al. 2007).	Individuals have positive expectations about their future. Individuals engage in efforts towards desired goals.	Communities provide positive opportunities for people's future.	Opportunities are created to positively influence individual and community health outcomes.
Physical Health	A state of complete physical, mental and social well-being and not just the absence of disease or infirmity.	Individuals lead healthy lives Individuals are able to have optimal levels of wellbeing	Communities have a high percentage of physically and mentally healthy individuals.	Physical health of the population has improved. People live healthier, happier, longer lives.

				Communities are able to access services to improve their health and wellbeing.
Self-determination	A psychological construct which refers to the internal motivation of the self to behave in an autonomous and controlled way.	Individuals experience greater autonomy in their everyday life. Individuals are able to express their individuality and self-identity. Individuals are able to regulate their behaviour in congruence with their values and needs. Individuals are able to make informed decisions about participating in support services which will best meet their needs and improve their health and wellbeing. Individuals are able to maintain their independence as they get older and are able	Communities are aware of their needs as well as assets.	Communities are able to make informed choices about their political, social, and cultural development in order to create healthier neighbourhoods. Local communities participate actively in public affairs and decision making.

		to access appropriate support when they need it.		
Spirituality and Personal Meaning	The quality to strive for meaning and purpose by believing in a spiritual dimension. The striving to answer infinite questions when facing emotional difficulties, stress, illness or death.	Individuals construct their own spirituality and meaning which help them cope with stressful and threatening situations. Individuals have a purpose in life, which is determined by their personal meaning and values.	Communities encourage individuals to express their spirituality and personal meaning, as well as provide an environment where they can be developed.	People are contributing to societal change through their different spirituality and meaning of life. Fairness and equality for all irrespective of spiritual or religious backgrounds.
Trust	Trustworthiness is experienced in reciprocal relationships. Forms of trust include close interpersonal relationships (such as family and close friends) and social connectedness with the wider community or members of the outside community.	Individuals trust in others. Individuals are able to build different social relationships	Communities have high levels of trust and co-operative norms.	Society is safe from crime, disorder and danger as individuals and communities trust each other.

3.1. Affect

One of the factors mentioned in the literature on wellbeing and resilience is the experience of positive and negative affect. The literature on social capital did not explicitly make the link between social capital and affect, but it did suggest that participation in social networks is related to enjoyment of life – referred to as positive affect.

Affect refers to particular feelings and emotions experienced by an individual at a certain point in time (OECD 2013). There is sufficient evidence to suggest that positive affect protects and improves physical health, psychological wellbeing and resilience of individuals in numerous ways (Nath and Pradhan 2012; Lyubomirsky et al. 2005). The experience of positive affect does not undermine the fact that people also experience negative affect, but research suggests that positive affect can help individuals to restore autonomic (unconscious or involuntary) responses after the experience of adverse negative affect (Fredrickson, 2001).

There is further evidence that positive affect leads to the development of adaptive characteristics in individuals and nurtures behaviours that are goal oriented (Lyubomirsky et al. 2005). Positive affect is also proven to have benefits in terms of marital quality, creativity, sociability and productivity (Lyubomirsky et al. 2005).

3.2. Access to Resources & Healthy Environments

A sustained healthy environment is a significant factor in the promotion of health, wellbeing and resilience. Access to resources is referred by some researchers as the equal geographical distribution of health promoting amenities, facilities for physical activities, and nutritious and affordable food (Springer et al. 2006). In this respect, urban and rural planning and design of the built environment predicts the accessibility of different resources for communities and the healthiness of the environments in which they live (Springer et al. 2006).

Availability of resources is further proven to have an impact on the *behaviour* of individuals in their efforts to sustain healthy lives. Research also suggests that another form of resource accessibility is the establishment of different organisations in communities that enable individuals to access diverse forms of social capital (Bebbington et al. 1987). This, according to the literature, will further facilitate individuals to engage with key agencies and use available resources for the benefit of their community. Moreover, access to different forms of social capital is a pathway to co-production between local and external organisations or community initiatives (Springer et al. 2006).

3.3. Culture

Culture can be defined as the knowledge, beliefs, values and systems of symbolic meaning that individuals draw on in everyday life (Spencer-Oatey 2012). Values and norms within communities are mainly related to the establishment of different forms of interpersonal relationships, whereas knowledge and belief systems are thought to have an impact on the resilience of communities and on people's perceptions about health and wellbeing (Harper 2001).

As culture may determine the goals of individuals and communities related to sustaining a healthy lives (Diener et al. 2003), it is important for researchers and practitioners to understand how different values, norms and beliefs impact on assets leading to the improvement of the wellbeing of communities. However, individuals possess personal values and beliefs which sometimes differ from the mainstream culture.

The concept of belief is still vague, although the literature suggests that if analysed at the individual level it often refers to levels of hopefulness and optimism (Benzies & Mychsiuk, 2009 as cited in Distelberg et al., 2015), which are closely linked to improved wellbeing. When considered from the family or community perspective, belief systems are related to traditions and rituals (Walsh, 2003).

3.4. Empathy & Helpfulness

Empathy refers to the ability of individuals to perceive and be sensitive to the emotional experiences of others, as well as being motivated to care for their wellbeing (Decety, 2015). The factors that influence the ability to empathise include motivational forces (the need to belong, situational cues (attraction), individual or group differences (such as gender and ethnicity), levels of education, self-monitoring and awareness, culture and relationship-specific factors (Sherman et al. 2015). It influences parental care and attachment between caregiver and infants, enables pro-social behaviours, and plays a role in inhibiting aggression (Decety 2015).

Moreover, empathy sustains greater cooperation between individuals and lower level of conflict between community members (Decety 2015). Empathy is also evidenced to increase the likelihood of helping others in distress based on empathetic concern (Myers et al. 2014).

3.5. Interpersonal Relationships

Interpersonal relationships were identified as one of the main assets influencing the health and wellbeing of individuals (Hopkins et al. 2015; Foot 2012; Sigerson and Gruer 2011). They are often seen as being part of the phenomenon social capital and in this regard interpersonal relationships have been conceptualised according to the different social capital subtypes – bonding, bridging, and linking.

For the purposes of ABIF development, the term ‘interpersonal relationships’ refers to all the varying aspects of social relationships identified in the first part of the review related to wellbeing, social capital and resilience. This includes social support, social integration, social contribution and social connectedness.

Social networks have structural characteristics describing the context of interpersonal interaction, as well as functional aspects referring to emotional support, companionship and advice. According to Portero and Oliva (2007), functioning social relationships impact positively on the quality of life of individuals but they need to be analysed in the context of stressors that people

experience. Furthermore, the impact of social networks can be understood by examining how networks work, as well as how they are formed (Smith and Christakis 2008).

One important aspect of the formation of social networks is the tendency of individuals to form relationships and bond with similar others; a phenomenon known as homophily, which is thought to play a role in how social networks affect health (Smith and Christakis 2008). Furthermore, different network properties can influence varying health phenomena and can function contrarily in different contexts.

Another aspect of social networks influencing individuals' lifestyles is conformity to social norms relevant to health and wellbeing (Holt-Lunstad et al. 2010). These norms are culture specific and vary from context to context. Finally, though the literature suggests that interpersonal relationships are related to increased self-esteem, it has been argued that social networks need to provide a balance between altruism (selfless concern for the wellbeing of others) and egocentrism (the individual as the centre of all things) in order for this self-esteem to be sustained (Cattell 2001).

3.6. Optimism

The literature review found that optimism – hopefulness and confidence about the future or realisation of something – may positively influence the resilience of people after an experience of adverse negative affect. Optimism is also perceived to have a positive impact on the coping strategies individuals use in difficult situations, and may lead to positive changes in psychological wellbeing over time (Pinquart et al. 2007).

Optimism has also been associated with experiences of high levels of postive affect and reduced negative affect, and as a significant predictor of positive physical health outcomes (Rasmussen et al. 2009).

3.7. Physical Health

In the first part of the review, physical health was evidenced as a predictor of high levels of subjective wellbeing (Lindert et al. 2015). While the literature did not refer to physical health as *a predictor* of resilience and social capital, it did suggest that physical health is *a result* of high levels of resilience and social capital (Portero and Oliva 2007; Lewis et al. 2014; Fry 2000).

The second part of the review conducted to identify and define overlapping assets and their impact on individual, community and structural levels, did not identify any other ways in which physical health can impact on wellbeing, social capital or resilience. Nevertheless, this has been included as an ABIF indicator as any positive change in physical health clearly serves as a sign for improvement in the lives of individuals and wellbeing of communities.

3.8. Self-determination

Self-determination was identified as one of the main factors to have a positive impact on wellbeing, social capital and resilience at an individual level. Autonomy, self-efficacy, sense of coherence, internal locus of control and confidence were all associated with this attribute in the literature. As self-determination is related to the internal motivation of the self to behave in an autonomous and controlled way (Lewis, Kimiecik, Horn, Zullig, & Ward, 2014), it follows that self-determination can be an overarching indicator for individuals' autonomy, self-efficacy, and social coherence.

Research suggests that self-efficacy – people's beliefs about their capabilities to control events impacting their lives (Posadzki and Glass 2009) and social coherence – one's ability to construct a meaningful and managable world view (Seaman et al. 2014) – can be synthesysed in one theory (Posadzki and Glass 2009).

According to self-determination theory, three innate, long-standing needs have to be met for an individual to develop self-determination and psychological wellbeing: autonomy (or independence), competency (or skill), and relatedness (or empathy) (Ryan and Deci 2000). Self-determination is high when internal regulations of behaviour are assimilated to the self and are in

congruence to the individuals' values and needs (Ryan and Deci 2000). This suggests that intrinsically motivated people will experience greater autonomy in their everyday life. Furthermore, internally motivated pursuits provide a way for people's individualities and self-identities to be expressed (Caldwell and Witt 2011).

According to Martin and Paul Hill 2012, relatedness and autonomy may not necessarily lead to improved wellbeing and life satisfaction when societal poverty is an issue. The authors state, however, that even in a context characterised by living standard deprivation, an individual's ability to have a say in his or her own destiny may have a positive impact in softening the impact of poverty on the person's wellbeing (Martin and Paul Hill 2012).

3.9. Spirituality & Personal Meaning

Spirituality was identified as an asset that can influence wellbeing (Lindert et al. 2015). The literature suggests that participation in spiritual practices, a belief and degree of comfort derived from religion, sense of inner peace with self, and accessibility to religious resources are significant predictors of wellbeing (Fry 2000).

According to Krause et al. (2016), spirituality also helps individuals reduce the negative impact of stressful life events on their health and wellbeing (Krause et al. 2016). Furthermore, there is evidence to suggest that spiritual or religious-based participation in social networks reinforces the production of bonding, bridging and linking forms of capital (Baker and Smith 2010).

Other existential factors such as personal meaning and life values can have an impact on the way in which individuals cope with stress and how they understand wellbeing (Fry 2000). Personal meaning – related to life purpose and the strategies individuals use to achieve personal growth – has a strong association with positive wellbeing dimensions (Zika and Chamberlain 1992).

3.10. Trust

Trust, described by Erikson (1953) as a predisposition for the development of a healthy personality, is one of the contributory factors for the experience of wellbeing. The literature recognises trust as a measure of social capital as it is an integral part of building different social

relationships (Algan and Cahuc 2014; McPherson et al. 2013). Trust is also associated with improved wellbeing as it encompasses sentiments of happiness and increased life-satisfaction (Michaelson et al. 2012; Algan and Cahuc 2014; Helliwell and Wang 2015).

Trust – in close interpersonal relationships (such as family and close friends) or social connectedness with the wider community or members of the outside community – is related to the dependability experienced in a reciprocal relationship (Ashleigh et al. 2012). It has been suggested the tendency to trust others is correlated with improved life satisfaction and wellbeing (Ashleigh et al. 2012; Helliwell and Wang 2015). A further factor associated with low levels of wellbeing is risk aversion, which suggests that when individuals cannot meet their needs for psychological security they tend to loose trust in others (Ashleigh et al. 2012).

3.11. Discussion

This section reviewed the literature to identify and define overlapping assets and their applicability at individual, community and structural levels. These key indicators will serve as a *template* for applications of a co-produced ABIF, but may be *adapted* at baseline depending on the views and assets identified when the framework is first applied. In essence, this template is a *starting point* for practitioners applying and co-producing an ABIF with particular communities in different settings. An example of the process and steps involved in implementing such a co-produced ABIF is provided in Part 2 of the report when the framework is first applied with the 'Roma community'. This particular community was selected to build on findings from previous asset-based research on health inequalities among Roma living in Glasgow's South Side funded by NHSGGC (de Andrade 2014). Despite being one of the most socially excluded and disadvantaged BME groups with poorer health than the majority population in Glasgow, Europe and indeed the world, these inequalities are still largely unresearched. The lead researcher has established relationships with several community members and groups, who expressed interest in taking part in further research.

For the ABIF to be used as an evaluation tool to capture whether, how and why changes in health, wellbeing and inequalities through creative community engagement occur, indicators

need to be “measured” at the start of a community engagement; throughout the engagement process; and at the “end” of a co-produced initiative or setting (assuming there is an “endpoint” – this will be discussed later).

The next step in developing an ABIF is therefore to turn to the literature to determine what evidence already exists on the evaluation of asset-based approaches.

4. Evaluation of Asset-based Approaches

The literature acknowledges that measuring the impact of asset-based approaches on health outcomes is a multifaceted and difficult undertaking, and there is a limited evidence-base demonstrating a link between actions to strengthen individual and community assets, and improved health (Sigerson and Gruer, 2011).

While academic studies and documents from the grey literature identify several challenges and make recommendations (Sigerson and Gruer 2011; Hopkins et al. 2015; Foot 2012; Foot and Hopkins 2010), the review did not identify any established frameworks for the evaluation of asset-based working.

Asset-based approaches are introduced to complex systems, such as communities and neighbourhoods, in which different perspectives on what the issues, needs and resources exist (Hopkins et al. 2015). Furthermore, asset-based approaches for public health address phenomena recognised as “health assets” (e.g. social capital, resilience, social networks) which are inherently complex and contextually determined (Hills et al., 2010). It has therefore been argued that in order to evaluate these complex phenomena and their impact on outcomes, researchers would require a more comprehensive evaluation than the traditional linear approach – one which identifies the internal structure of assets, their relationship with context and causal connection to health outcomes (Foot 2012; Hills 2010; Sigerson and Gruer 2011).

In the report *“What makes us healthy? The asset approach in practice: evidence, action, evaluation”*, Davies (2012) notes that one of the steps towards such evaluation is the shifting of focus from the traditional approach of asking ‘what works’ to understanding the nature,

formation, natural history, interrelations and dynamics of social problems and social accomplishments, as well as researching the values that underpin individual actions. He argues further that when working within public mental health the research interest should be oriented towards the context and its impact on interventions and not only towards individuals as subjects (Davies, 2012). Evaluations of asset-based approaches therefore need to address the *'mechanisms by which the desirable outcomes are made more likely by the interaction of actions and context'* (Davies 2012, p.58).

Hopkins and Rippon (2015) offer an approach to measuring the mechanisms underlying change while taking into consideration the complexity of systems and context, namely *'theory of change'*. The theory of change approach incorporates the principle of realistic evaluation, which situates context at the centre of research by trying to understand how outcomes are formed (Hopkins et al. 2015; Wimbush and Watson 2000).

Another core component of evaluating asset-based approaches is the close participation of *whose* assets and capacities are being supported in the different stages of interventions (Foot 2012). This challenges traditional evaluation methods, which exclude participants from decision-making in the evaluative stages of the project (Hills et al., 2010). As asset-based approaches aim for "meaningful participation" while trying to achieve programme outcomes, participants' reflective practices need to be included in evaluations (Hills et al., 2010). Hills et al. (2010) therefore argue that researchers and practitioners need to challenge orthodox evaluations by examining the relationship between external evaluators and deliverers of the programme, and to re-think what is considered as significant information to explain the "success" of a programme.

The authors also suggest that an integrated approach is needed to assess asset-based approaches including process and outcome evaluation; formative and summative approaches; as well as participatory and empowering approaches. Similarly, Davies (2012) proposes that the complexity of asset-based approaches can best be measured by using participatory methods that capture the actions on assets leading to desirable outcomes, and by making evaluation a "rflective practice" where narratives (personal storytelling) are used as an evaluative method.

A further approach for mapping outcomes of asset-based approaches is "logic modelling", which looks at long-term, medium-term and short-term outcomes. This approach may be valuable in understanding improvements in health assets as intermediate outcomes, which together may lead to progress in overall health and social outcomes (Hills 2010; Welsh and Berry 2009; Miller 2015). Methods of evaluation are further explored in the sections below.

4.1. Personal Outcomes Measures

The literature review identified several articles referring to personal outcomes measures (POM) as an evaluation of asset-based approaches (Miller 2015; Hopkins et al. 2015; Cook and Miller 2012). POM explore whether the outcomes of services correspond to the expectations of individuals and communities (Cook and Miller 2012; Apps et al. 2013). This measurement approach facilitates trust between practitioners and participants, and provides a common language and shared confidence across services (Barrie 2013). Furthermore, POM increase the responsibility and ownership of outcomes by participants and communities (Barrie 2013), which are core principles underpinning asset-based approaches.

The *Talking Points Personal Outcomes Approach* was developed in Scotland by the Joint Improvement Trust (Cook and Miller 2012) building on the work of Social Policy Research Unit at the University of York, which analysed outcomes that service users view as important. This approach is mainly used for the evaluation of services in health and social care.

The conceptual underpinning of Talking Points is based on a framework with ***three main types of personal outcomes*** (Barrie and Miller 2015):

- **process outcomes** – related to participants' experiences of using a service.
- **change outcomes** – referring to the improvement that participants are seeking.
- **quality of life outcomes** – features of a person's whole life that they are working towards achieving or maintaining in partnership with services and other forms of support.

The Talking Points Approach identifies three core steps in its implementation (Cook and Miller 2012). The first stage is **engagement with participants**, which aims to establish meaningful outcomes conversations. Here, participants have the opportunity to elaborate on what outcomes are important for them. If this engagement is person-centred rather than driven by service evaluation or policy data collection demands but instead, it may have an empowering effect on stakeholders (Apps et al. 2013).

The exchange process – or means of engagement – in Talking Points is semi-structured conversations and based on the principle of active listening to make sense of what matters to each participant (Cook and Miller 2012). Throughout this stage, the three different types of outcomes are identified and recorded.

The **recording** of information is the second stage. Talking Points suggests that the recording of outcomes should be informed by a range of resources (such as semi-structured interviews with participants, participatory observation or group work) (Cook and Miller 2012). The approach uses qualitative methods for recording and language that is meaningful to the person.

In the final stage, participants and practitioners start thinking on how these outcomes might be achieved by **analysing the data.** The approaches suggested by Talking Points are qualitative (thematic analysis, content analysis or group discussion) and quantitative (counting numbers of participants where outcomes are improved or mapping outcomes change with visual tools).

To summarise, Talking Points is grounded in the notion that outcomes-based assessment and planning should be informed by semi-structured interviews based on the framework of outcomes that are important to individuals (Barrie and Miller 2015; Cook and Miller 2012). In their report *Measuring Personal Outcomes in Service Settings: Collected Briefings from the Meaningful and Measurable*, Barrie and Miller (2015) present some of the challenges related to using personal outcomes data in service settings. The authors emphasise that each outcome may not be important to every individual at a particular point in time (Barrie and Miller 2015). Practitioners using this approach therefore raise concerns about *who* should complete the mapping and *when* it is appropriate to do so to ensure outcomes are not prematurely allocated to specific categories, which may only be important to practitioners (Barrie and Miller 2015).

The literature identifies several challenges related to the measurement of personal outcomes. First of all, researchers and practitioners need to be clear about the purpose of measuring outcomes (Miller 2011). Different outcomes measures give emphasis to either judgement or improvement so those applying the approach need to be sensitive to include measurement tools for both (Miller 2011).

Secondly, several authors have identified challenges related to the use of quantitative and qualitative measurements (Barrie & Miller, 2015; Miller, 2011; Raleigh & Foot, 2010). Quantity measures have been criticised to provide limited evidence if they are analysed separately from qualitative data. As an example, if a project measures an increase in social relationships for people with addiction it needs to also gather qualitative data about the type of relationships and their influence on the individual (Rudd 2015).

Finally, it is important for researchers and practitioners to consider the meaning of outcomes for participants, as well as the context in which these outcomes are measured to develop culture sensitive research (Barrie 2013). An example of the application of the POM approach is presented below.

4.1.1. Recovery Outcomes Counter (I.ROC)

The POM **Recovery Outcomes Counter (I.ROC)**, developed by the mental health voluntary organisation Penumbra, is a tool created to measure the recovery journey of individuals and is facilitated by a self-assessment questionnaire (Rudd 2015). The tool was developed based on the understanding that personal outcomes are features of *wellbeing* defined here as a multi-dimensional concept in which inter-relationships between dimensions have significance for outcomes. In this context, wellbeing also points to inter-dependencies between various aspects of human life (Barrie and Miller 2015).

I.ROC is used together with the Home Opportunity People Empowerment (HOPE) framework for wellbeing, and both tools are mapped onto the Talking Points Personal Outcomes Approach.

The I.ROC consists of three indicators for each area of HOPE respectively: mental health, life skills, safety & comfort, physical health, exercise & activity, purpose & direction, personal network, social network, valuing myself, participation & control, self-management, hope for the future (Clark et al. 2015).

(i) Indicators

Indicators were identified from evidence gathered from UK health and social services and an examination of existing tools (Barrie and Miller 2015; Monger et al. 2013). Two papers in particular were used in the development of the I.ROC tool. The first, a Scottish Government publication presenting 55 indicators for mental health (Parkinson 2007), structures indicators under the categories *Individual, Community* and *Structural*. Indicators were developed using a mixed approach drawing from current data and policy, evidence, expert opinion and theory.

The second, the Outcomes Star tool (Appendix 1), was developed for use in homelessness services to support and measure change when working with vulnerable people (MacKeith 2011).This tool was based on client group discussions and individual service users' assessments and consists of eight sections which can be evaluated on a ten points scale: promoting good health; meeting emotional needs; keeping your child safe; social networks; supporting learning; setting boundaries; keeping a family routine; and providing home and money.

In 2011, the Outcomes Star approach (see Appendix) was the most frequently used tool in homelessness research (Homeless link, 2011) and is cited as a valid and reliable measurement tool (Burns, MacKeith and Graham, 2008; Killaspy et al, 2012; York Consulting, 2013) based on indicators with sustainable impact (Triangle Consulting, 2014; McNeil, 2012).

(ii) Means of Engagement and Outcomes Measurement

I.ROC uses both quantitative and qualitative data to help fully understand what outcomes individuals want to achieve and what support they need to achieve these outcomes (Rudd 2015). Moreover, I.ROC aims to *measure the shift over time* for each of the indicators based upon Penumbras' perception of recovery that people start from different places (Rudd 2015).

Quantitative data collection is prompted by questions for each of the twelve standardised indicators (Barrie & Miller, 2015). Each indicator question asks the individuals how often they have felt a particular way (for example, mentally or emotionally happy) or whether they have been involved in group activities within the past three months. Indicator question items are combined with interval scales which supports statistical representation (Barrie and Miller 2015). Furthermore, each question is accompanied by graphics and prompts which assist the participants completing the questionnaire. After completing I.ROC the participants are able to see an immediate graph illustration of their results.

Practitioners working on the Meaningful and Measurable project argue that an increase in scores does not necessarily reflect improved outcomes and, therefore, narrative data should be considered alongside the measures to provide a sense check of statistics. Participants are also given a qualitative data "answer sheet" so significant events, thoughts and reflections can be for monitored and recorded about each indicator. This allows for the identification of patterns, common themes or categories within individual narratives (Rudd 2015).

(iii) Limitations

The I.ROC tool is considered to be a reliable and valid measure of recovery and has been tested against two leading measures of recovery: Recovery Assessment Scale) and outcomes (BASISI-32) (Monger et al. 2013). The tool provides the opportunity for scores to be aggregated so that they can show changes in the mean scores for each indicator between baseline and latest I.ROC. Despite the fact that figures can be used to represent a number of participants making improvements against I.ROC indicators, Penumbra is still reluctant to produce such figures as only changes in mean scores are statistically significant; and contextual information needs to be provided in order to make sense of numerical patterns (Barrie and Miller 2015).

An Evaluation Report based on semi-interviews with Penumbra staff, case file audits and focus groups has been produced to identify strengths and weaknesses of the I.ROC measurement tool (Rudd 2015). The report concluded that although staff have a good understanding of personal outcomes, there are challenges related to the recording practice. The main issues were related to a lack of clarity over whose record is it (as information needs to be recorded together with

service users), and the different types of records (such as daily notes versus I.ROC comments). The report gives recommendations for the incorporation of a more structured approach to note taking by linking each activity to several outcomes. I.ROC limitations provide illustrations of some of the difficulties researchers and practitioners may face when using personal outcomes evaluation approaches.

4.2. Theory of Change and Logic Modelling

Theory of change (ToC) is considered to be a useful evaluation method when working with asset-based approaches as it enables a collaboration between practitioners and participants, while assessing different aspects of a "community system" and its complexity (Hopkins et al. 2015; Foot and Hopkins 2010; Cook and Miller 2012; Wimbush and Watson 2000). It is based on the principle of realistic evaluation, which considers the context and mechanisms of an intervention to be critical features in its outcomes (Wimbush and Watson 2000).

The identification of a "theory" of an intervention allows practitioners to transfer interventions to other contexts and settings. It also allows researchers to identify the *processes* by which change comes for a particular group or individuals (Hopkins et al. 2015). Furthermore, the approach takes into account that methods and goals of a particular project might need to be adjusted as its implementation progresses – a crucial feature in asset-based working.

A theory of change approach analyses three levels of asset-based working: individual; group; and societal (Hopkins et al. 2015). The outcomes are also differentiated on the basis of a time dimension to determine the relationship between the initial inputs and expected eventual outcomes (Wimbush and Watson 2000).

While the terms "theory of change" and "logic modelling" are sometimes used interchangeably and can be blended together, they are distinct. Logic models sketch out a programme or initiative's components and serve as useful tools to help partners clearly identify outcomes, inputs and activities. Theories of change, on the other hand, link these outcomes and activities to *how* and *why* the anticipated change is expected to happen. This requires a justification of each step, for example, an articulation of why an activity is undertaken and why it will cause change

(Hopkins et al. 2015). Logic modeling also requires the identification of programme components, but it does not explicitly show why activities are expected to produce outcomes (Barrie and Miller 2015). .

Theory of change requires the identification of indicators, while logic modeling does not. The latter helps organisations adopt an outcomes approach by clarifying what they want to achieve, and provides an opportunity for researchers and practitioners to demonstrate how soft outcomes can be viewed as outcomes in their own right and can contribute to longer term or more strategic outcomes (which could be applied to the Single Outcome Agreement in Scotland). According to this approach, a project might bring change before its final outcomes are achieved (Barrie and Miller 2015). Examples of both approaches are presented below.

4.2.1. Project Superwomen

Project Superwomen started as a collaboration between a social service provider, a non-profit employment training center and a domestic violence shelter to create long-term, livable wage employment opportunities for women who had been victims of domestic violence (Project Superwoman 2004). Before beginning the Theory of change process, participants were invited to think carefully about: (1) their ultimate goal for the initiative; (2) how they wanted to use "the theory" (3) their resources and capabilities; (4) who they want to work with. Any or all of these could change once the process began, but it was essential to think about these things at the outset.

The project included following five steps:

1. Identifying goals and assumptions: participants agreed on the goals they want to achieve (long-term employment). Participants were then invited to identify the preconditions necessary for the change to happen. These included coping skills, marketable skills and appropriate workplace behavior.

2. Backwards mapping and connecting outcomes: a more detailed stage of the mapping process followed after laying out initial expectations and a simple change framework. In this step, outcomes were added or changed and connections between outcomes were illustrated (for

example, women start receiving counselling which helped them identify how to get help and deal with their issues.)

3. Developing indicators: this stage focused on how to measure the implementation and effectiveness of the initiative. By collecting data on each outcome, the initiative identified what was or was not happening and explored why. Examples of indicators identified by participants included employment, programme graduation and attendance.

4. Identifying interventions: after laying out the change framework, participants focused on the role of interventions (those things that the program (or initiative) must do to bring about outcomes). Example of interventions identified included leading group sessions; providing help for short-term crises such as housing evictions or court appearances; and the provision of one-on-one counselling.

5. Writing a narrative: after completing the indicators and framework (which included accounting for assumptions, justifications and interventions), participants were invited to describe the programme. The narrative helped stakeholders explain their programme to outsiders, and gave them confidence in the logical underpinnings of the programme. Writing the narrative made it possible to coherently explain how the sequence and interventions make change possible.

4.2.2. The Women's Project

Practitioners on The Woman's Project, for example, used logic modelling to establish the relationship between inputs, outputs, outcomes and impact as it aimed to reduce unwanted teenage pregnancy by offering support and group work to young women (Cupitt and Ellis 2003). Input was provided by staff who offered one-to-one support sessions (output) to increase young people's confidence (outcome) and respectively impact on the reduction of social exclusion. Three levels of outcomes – short-term, medium-term and long-term – helped specify circumstances. Logic modeling provided a linear approach in identifying which inputs lead to which outputs.

4.2.3. Limitations

The literature identifies some disadvantages of using ToC that need to be considered in ABIF development so the framework can be used as an evaluation tool. Bours and Pringle (2014) argue that:

ToC approaches are time-consuming. In this respect, practitioners would need to allocate sufficient resources (time and money) towards the development of the interventions, engagements or services using ToC.

- ToC can be confusing to some if it includes diagrams with many interconnections between inputs, activities and outcomes. It is more likely that ToC will be successful among community members if it is introduced in a stepwise fashion. The ABIF will facilitate this.
- ToC can run the risk of becoming a 'glorified logframe' (James 2011:10) rather than a vehicle for social change. The ABIF will provide a mechanism for capturing the reasons for why change has or has not occurred (which will drive future actions), rather than simply providing a list of what has or has not occurred.

There are further limitations associated with the use of logic modeling approaches. These are summarised below. According to Sundra et. al. (2013):

- Logic modeling provides a linear analysis of data. However, the relationships between inputs and outputs are expected to be complex, interactive and recursive over time.
- Logic modeling only illustrates expected outcomes. Unexpected outcomes, however, may also occur in a programme, intervention or community engagement.
- Logic modeling faces the challenge of casual attribution (it assumes casual connections, but does not prove that a programme or intervention has caused the observed result).

4.3. Discussion

This section reviewed the general recommendations provided by the literature on the evaluation of asset-based approaches. These recommendations can be summarised as follow:

- Researchers and practitioners need to identify the internal structure of assets (Foot 2012; Hills 2010; Sigerson and Gruer 2011).;
- Identifying mechanisms by which change happens is key. Practitioners should look at the interaction between action and context, assets and context (Davies 2012).
- Participants reflective practice should be included in the evaluation (for example, storytelling) (Hills et al., 2010).
- Practitioners should use participatory and empowering methods to engage with communities and to capture actions on assets leading to outcomes (Davies 2012).
- Evaluation should look at long-term, medium-term, and short-term outcomes in order to meaningfully understand improvements in health and wellbeing (Hills 2010; Welsh and Berry 2009; Miller 2015).
- Researchers should use both formative (looking at participants' development at a particular time) and summative (assessment of participants where the focus is on whether they have achieved the outcome) approaches in the evaluation (Hills et al. 2010).

The outlined recommendations will inform the development of the ABIF.

The section further presented three main methods of evaluation which are commonly referred to by the literature on asset-based approaches- personal outcomes, theory of change, and logic modelling.

Personal outcomes approaches consist of three steps which will be taken into consideration when developing the ABIF guide to co-production:

- Step 1: Engagement with participants to elaborate on what outcomes are important to them. The approach categorises outcomes in three categories: **process outcomes** – related

to participants' experiences of using a service; **change outcomes** – referring to the improvement that participants are seeking; **quality of life outcomes** – features of a person's whole life that they are working towards achieving or maintaining in partnership with services and other forms of support.

- Step 2: Recording of information, which is informed by a range of resources. These resources should use language which is meaningful to participants and should include them in the process of recording.
- Step 3: Analysing the data, which is done in collaboration with participants. The analysis of data could use both qualitative and quantitative tools.

The following main principles of ToC approaches will also be considered in the development of ABIF:

- The analysis of the mechanisms through which change happens (answering the questions how and why).
- The analysis of three levels of asset-based working: individual, group and societal.
- The adjustment of methods and goals of projects during the implementation process.

Logic modeling methods will be incorporated within the structure of the ABIF by addressing short-term, medium-term and long-term outcomes.

The next section turns to the literature to explore how data can be collected and measured for each of the proposed ABIF indicators.

5. Measurement of ABIF Indicators

Table 3 summaries how data may be collected for each of the developed ABIF indicators based on recommendations from the extensive literature review. It also presents the "aim of evaluation" for each indicator's measurement; reviews existing measurement approaches and means of data collection; and includes a commentary on how the measurement of each indicator can be implied to serve the aims of co-production and asset-based working.

Table 3 Measurement of ABIF indicators

Indicator	Aim of Evaluation	Review of Existing Evaluation Approaches	Means of Data Collection	Commentary
Affect	To capture data on positive/negative emotional states experienced by the community members involved in asset-based initiatives before, during, and after the project/programme/ intervention. To identify whether there has been a shift in levels of experienced positive/negative affect of the local community and its members during and after participating in the engagement. To identify whether/how this shift is related to any of the activities included in the project.	The evaluation of affect can be oriented towards a **specific emotional state** and its related behaviour (e.g. anxiety, calmness) or **a global domain of content** (e.g. positive and negative emotions). The pleasure dimension of affect is related to the experience of love, joy and pride. Displeasure is related to fear, anger, sadness and shame (Ekkekakis and Russell 2013).	The experience of affect can be gathered through **questionnaires** including 5- or 10-points feeling scales (OECD 2013; Stevenson 2013). The practitioner reads out loud a list of ways the interviewed person might have felt (the previous day or previous month, during the intervention, after the intervention) and the person answers on a 5- or 10-points-scale. Information about the activation event for the experience of pleasure or displeasure can be collected through **time-use diaries** (OECD, 2013). Time-use diaries collect information about the type of activity, the location,	Interpretation of results given by scales or questionnaires could cause some problems when applied to various cultures due to cultural diversity. For example, the typical response to the question "How are you feeling?" in many Western cultures is "good," the baseline Feeling Scale rating is usually +3 (which is anchored by the adjective "good"). In other cultures, however, the rather bold statement "I feel good" is reserved for only those cases in which a preceding positive event would justify "feeling good." It is important for researchers and practitioners to firstly **identify and integrate the baseline rating** to the specific culture *before* using the scale. When using time diaries in co-

			the people with whom the person was, and the purpose of the activity. These are valuable co-variates when analysing the experienced affect and its impact on wellbeing (OECD 2013). As co-production may include various partners as equal and active participants, practitioners can also use **reflective diaries** to collect data. This will capture their own affective experiences and allow for an in-depth level of analysis when cross-referencing with community members' experiences.	production, data should be analysed **together with the individuals** who produced them. This allows them to contextualise and elaborate on the experience and explain what meaning it has had for them. Practitioners will then be able to explore **what change is meaningful for community** members and to analyse the 'theory of change' – in what context and under which conditions does change happen? For the ABIF, the **dimensional approach** is recommended. Practitioners should examine the global domain of the experienced affect – which emotions cause pleasure or displeasure? – and what was the *activation event* (Russell 1980).
Access to Resources & Healthy of Environments	To evaluate how accessible different resources are for a specific community and how healthy the environment in which they	Access to resources is determined by the socioeconomic status (SES) of individuals and communities, where SES has been defined as a	A simple **questionnaire or semi-structured conversation / interview with community members** can capture this data.	As noted in the personal outcomes literature, it is very important to **understand what community members feel they have access to, how these resources are important to**

	live is. To account for communities' expectations and "wishes" with regards to access to various resources (including different organisations). To account for changes in the environment that community members would like to see. To understand what resources are important to community members and what they consider to be a healthy environment.	'differential access to desired resources' (Oakes and Rossi 2003, p.775). Access to resources is therefore measured through the use of **SES measurement tools.** Consider how SES influences different factors such as access to transportation to medical appointments, type of health insurance, type of healthcare facility and provider, availability for care (i.e. the ability to take time off work or availability of child care), and knowledge of appropriate care (Shavers 2007).	This will give participants with the opportunity to share their ideas about the particular topic in their own terms and facilitate the co-creation and evaluate the primary data (Newton 2010). **Creative approaches** should also be encouraged. For example, drawing pictures or taking photographs of their environments or journies to work if employed.	**them, and how they assess and experience their environment.**
Culture	To assess how cultural values, beliefs and norms can influence the improvement of wellbeing. To establish how community members, experience their cultural identity. What does it mean for them to belong to a	Due to its very broad conceptualisation, Culture **cannot be evaluated per se**. Culture has mostly been explored in **ethnographic and anthropological** research into the organisational	Norms, beliefs, and values of a particular community can be understood through the use of **interviews or observational studies.** Ongoing observation in particular facilitates a deep understanding of	It is crucial for researchers and practitioners to capture how community members exercise their culture. It would also be of interest for asset-based initiatives to determine **how culture influences the construction of the different assets** mentioned in the

	culture? What impact does it have on their everyday life? To measure how and whether creative co-production can encourage the expression of community cultural values, norms, beliefs, and rituals.	functioning of different community structures.	what cultural practices exist in a community and how these impact their everyday lives, interpersonal relationships, social structure, and how they use and experience their living environment.	framework. It could therefore be invaluable to include a **'cultural aspect' to the evaluation of each indicator**.
Empathy & Helpfulness	To identify whether a sense of empathy is present in a community. To identify the extent to which community members participating in a co-production initiative improve their likeliness to help others.	The literature distinguishes between measurement of **empathic reactions in a specific situation** or **empathy as a stable person's character trait.** There are three approaches to the measurement of empathy: **self-reported measures**, **behavioural measures**, and **neuroscientific measures** (Neumann et al., 2015).	**Self-reported questionnaires** include statements related to empathy with scales indicating whether participants agree or disagree. **Behavioural tools** include evaluations of experimental stimuli and performance on tests. Neuroscientific approaches include brain imaging techniques, EEG, EMG and automatic nervous system measures. Visual stimuli –pictures with people experiencing different emotions or expressing	Self-reported empathy measures can be used during the process of co-production. Interviews or structured conversations provide opportunities to **explore what empathy means to community members, how they experience empathy, and how they think empathic communication can improve community wellbeing**. **Observations of group dynamics** could help assess how community members express empathy towards each other.

			emotions in different scenes – can be used to measure individuals' empathic reactions. **Empathic questionnaires** can evaluate the stable empathy character of a person. These questionnaires use cognitive and affective statements which are answered on an agree-disagree-point scale (Zoll and Enz 2005).	
Interpersonal Relationships	To gather evidence on community members' existing interpersonal relationships. This will offer an understanding of levels of connectedness between individuals. To assess what types of interpersonal relationships, support systems and social networks exist and are favoured by particular communities.	As interpersonal relationships are elements of social capital, questions related to the levels and types of connectedness of individuals are usually **integrated in measurement tools for social capital** (Harpham et al. 2002; Harper 2001; Welsh and Berry 2009). **Distinctive features for social connectedness and participation** are:	**Relationship Mapping** is a useful tool (Welsh and Berry 2009). An individual is positioned in the middle of a diagram and people they know are plotted on it, putting them closer or further from themselves depending on the closeness of the relationship. After drawing the map, the individual should be	For asset-based working, it is also necessary to investigate **how community members perceive their relationships or lack of such** with the practitioners or researchers involved in the project. Similarly, it would be useful to gather researchers' perceptions of their relationships with community members. As co-production is based on the principle of equal and active participation of all

	To identify which relationships are considered important to community members and create opportunities to strengthen or deepen them.	- frequency and intensity of involvement with cultural, religious, leisure and social groups, voluntary organisations and clubs. - frequency of seeing and speaking to relatives, friends or neighbours. - depth of the socialisation network. - proximity of relatives or friends. - perceptions of social support and connectedness. - degrees of citizenship. - links to groups with resources (e.g. local government, aid agencies). - links to other communities (Harper 2001; Harpham et al. 2002).	asked further questions to acquire more information about the frequency and intensity of the drawn relationships and to **gain an insight into**: - How the person feels about their map? - Is there anything they want to change? - What is the perception of their own connectedness and what it means to them? - Functionality of the different relationships. - Who do they approach if they need advice, comfort or support? - What are the relationships they feel they can contribute to? This tool can be used at intervals during an intervention to assess whether and how the social networks and relationships have changed. This will also help individuals to see the changes they have made (Welsh and Berry	partners, it would be valuable to analyse how relationships between stakeholders are formed (or how they break down or are not sustained) throughout the duration of the project. Gathering **different stakeholders' perspectives** of how the context of a particular initiative might have had an impact on the development of these relationships would also be useful.

			2009). **Weekly diaries** can also be used to look at the frequency and involvement of community members in different groups, organisations and social networks (Welsh and Berry 2009). The completion of the diary can be followed by questions related to the satisfaction of the individual with the activities described in the diary, their sense of contribution and participation, and the things they would like to change. Diaries from different weeks can be compared to identify changes and reasons for these.	
Optimism	To measure levels of optimism in health and health outcomes before and after co-produced engagements. To capture changes in	One way of measuring optimism is asking individuals about their expectation for life (Carver et al. 2014). **The Life Orientation Test** which consists of	Ongoing engagements with communities through **observation, creative activities, conversations or semi-structured interview**s could identify potential	The measure of optimism in asset-based interventions or programmes will allow for gathering and understanding community members' perceptions about their future (at baseline).

	participants' expectations after participating in respective co-produced initiatives. To identify how optimistic or pessimistic views of particular individuals can influence the wellbeing and resilience of a community.	negative and positive statements to which people agree or disagree on a multi-point scale can be used to gauge this (Carver et al. 2014). **Examining patterns of individuals' attributions about causes of events** is also useful for evaluation. If people view past negative experiences as stable causes then they would appear to be more pessimistic, whereas when they see negative experiences as unstable their expectations for the future is predicted to be rather positive (Carver et al. 2014).	negative coping mechanisms and direct community members to appropriate services and/or offer healthier alternatives/	Changes can then be captured and understood by systematically applying the ABIF over time. In this way, practitioners will gain an understanding of which programme or initiative component had the biggest impact or initiated change.
Physical Health	To identity whether communities live healthy lives. To assess whether communities have and are able to maintain optimal levels of wellbeing. To evaluate changes in	It is difficult to operationalise health and measure it in a quantifiable way. Social researchers use **self-rated measures of physical health** which are considered to be reflective of physical health status, symptoms,	Research suggests, that when using self-rated health measures with adults it is more appropriate to use **measures with specified response options** (Eriksson et al. 2001).	Self-rated health measures seem to be appropriate evaluation tools for measuring physical health during co-produced initiatives. Researchers and practitioners should also **investigate what difficulties community members might encounter in**

	physical health or habits influencing on health and wellbeing before, during and after co-production.	function, and health behaviors (Fayers and Sprangers 2002). Self-related health measures can provide information about the physical health of an individual at a particular point of time, and also about their general physical health.		**sustaining good physical health and whether such opportunities were provided through participation in co-produced initiatives.**
Self-determination	To identify levels of self-determination before participation in asset-based working and whether there has been a change in their sense of self. To examine how community members perceive choice before, during and after participation in the co-production activity.	The literature identifies two approaches in the evaluation of self-determination levels. **The Basic Needs Satisfaction in General Scale (BNSG-S)** assesses the satisfaction of individuals' three basic needs (autonomy, competency, and relatedness) in a general context. The questionnaire consists of 21 statements answered on a not at all true/very true scale. **The Self-Determination**	The Basic Needs Satisfaction in General Scale (BNSG-S) and the Self-Determination Scale (SDS).	The downside of using these tools is that the ways of fulfilment and importance of the needs, as well as understanding of self-determination, are dependent on the values and goals shared by the culture of a specific community. Standardised questions would not provide a culturally sensitive evaluation and might disrupt any interpretation of results (Bailey 2012). If practitioners and researchers decide to use standardised measurement tools they would

		Scale (SDS) examines how aware people are of their feelings and sense of self and how they perceive choice in their own actions (Lewis et al., 2014). The tool consists of 10 items answered on a 5 point true or false scale.		need to test their reliability and validity for the specific culture by interviewing respondents about their understanding and significance of the three needs and self-determination.
Spirituality and Personal Meaning	To identify whether individuals identify with any spiritual sources of hope, strength, comfort, peace, love and meaning. To understand whether community members participate in organised spiritual practices and understand what these mean to them. To explore whether / how community members' spiritual practices influence their health and wellbeing. To explore community members' values and understand what personal	Spirituality is often evaluated through assessment inventories, which identify different aspects of spirituality and their relevance for the individual. An **established framework for the assessment of spirituality** has also been widely used in social work (Hodge 2001).	The framework includes **general open-ended questions** to gather information about the spiritual or religious traditions in which an individual has grown up, their personal spiritual experiences, and what meaning these experiences have for them. The second part of the framework consists of **questions which could give an interpretative aspect to initial questions.** They ask for information about the impact of the person's spirituality on their affect (for example,	The spirituality framework could be adapted to explore whether co-produced activities have an impact on community members' spiritual practices or relate to their personal values.

	meaning is to them.		what aspects of the person's spirituality give them pleasure?); behaviour (are there any spiritual practices that help the person deal with difficult situations?); cognition (what are the person's beliefs and what are they based upon?); conscience (how the person determines right and wrong; what are they key values?). The framework can be adapted to explore the personal meaning and values of individuals even if they do not identify with a particular spiritual belief.	
Trust	To evaluate community members' levels of trust in relation to their family members, community as well as those outside of communities such as practitioners, researchers and representatives from organisations involved in	A review of various measurement tools of trust suggests that **statements related to trust should include following facets**: reliability, benevolence, predictability, availability,	**Questionnaires** asking respondents about their level of agreement with various statements (Tschannen-Moran and Hoy 2000). Levels of trust in a community can also be	It is of great importance for researchers and practitioners to **look at the social and cultural context in which a trustful or untrustworthy relationship is embedded** to determine how and why context can influence trust and more specifically, how trust can be built in co-

	co-produced activities. To evaluate factors such as individuals' propensity to trust others, their perceptions about others reliability, and levels of risk aversion should also be included when evaluating individuals' levels of trust. .	dependability, consistency, openness, fairness, discreetness (Tschannen-Moran and Hoy 2000). **Statements related to the three different forms of trust** – family, community and organisational – should each incorporate all the above mentioned facets to provide a consistent observation and evaluation of individuals' trust. **The propensity to trust others can be evaluated by using generalised statements** such as 'Other people cannot be relied upon' or 'Other people lie to get ahead', etc (Ashleigh et al. 2012). The risk aversion aspect will evaluate levels of loss of trust to others (Ashleigh et al. 2012).	measured by looking at the **levels of participation in different community initiatives, organisations or social networks, and engagement in cultural practices.**	production (Tschannen-Moran and Hoy 2000). Researchers and practitioners would need to **acquire information about the meaning of trust for the community** – what do they perceive as trustful and untrustworthy relationships?

6. Summary

The first part of the report has presented findings of a critical literature review conducted to provide a foundation for the development of ABIF by defining the underpinning concepts of asset-based approaches in the academic and grey literature to inform framework indicators.

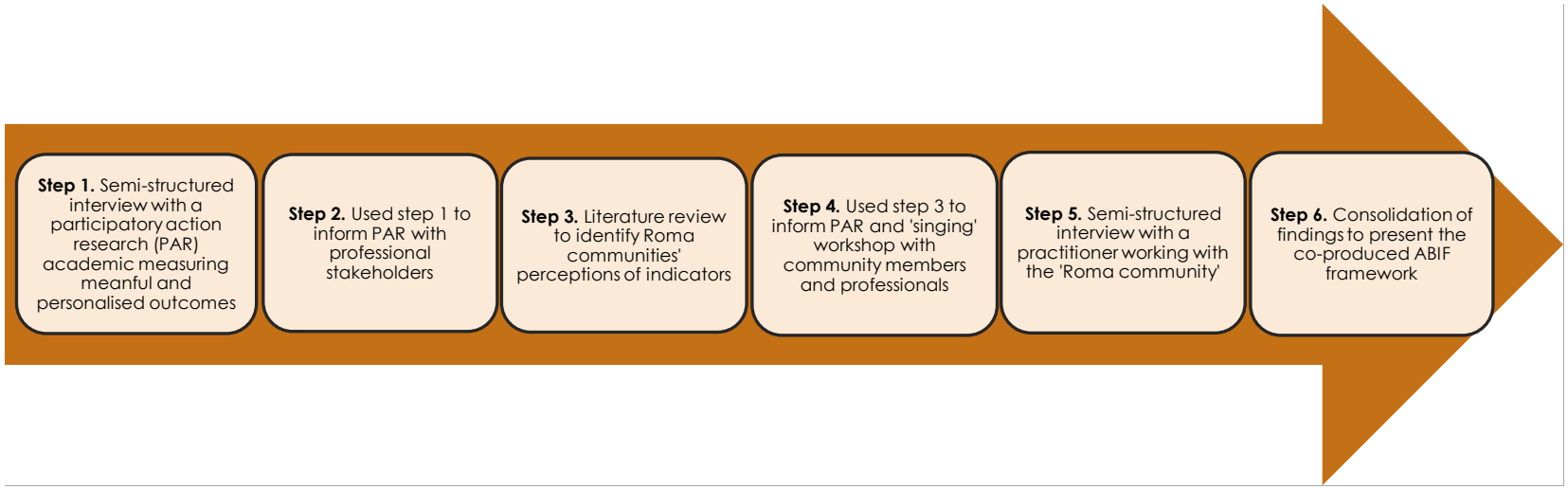
It has also identified and analysed the main methods used by researchers and practitioners to evaluate asset-based approaches. These findings will inform the development of an evidence-based template for an ABIF, which is piloted with the Roma community and presented in Part 2.

PART 2

7. Developing and Piloting the Co-Produced ABIF

This section now turns to the process of developing and piloting of the ABIF. Co-production calls for equal and active involvement of partners – community members, practitioners, voluntary sector representatives, researchers and policymakers amongst others – in the design and delivery of services, programmes or initiatives (de Andrade, 2016). Following the literature review, six steps involving engagement with various partners and community members were undertaken to develop the co-produced ABIF (see diagram).

As the pilot of the co-produced ABIF was with the "Roma Community", creative community engagement was complimented with a further literature review – integrated into the six steps below – to understand what previous studies have concluded about the health and wellbeing of community members.



7.1. Methodology

The first approach used for the co-production of ABIF was Participatory Action Research (PAR). In PAR, participants who are directly impacted by the research are involved in data collection, reflection and action working in partnership with practitioners, researchers and other community members.
Action is achieved through a reflective cycle, whereby different participants collect and analyse data then determine what action should follow (Baum et al. 2006).

PAR methods give a 'voice' to the marginalised; facilitate change in participants' situations; work with people to find tangible solutions to difficulties recognised by them; and raise critical awareness and analysis of participants' place in society (Dover & Lawrence, 2010; Hall, 2005; McIntyre, 2008). They embrace 'non-determinism' and 'non-linear' processes to allow ideas to emerge from organic engagements (Blacker & Regan, 2006; Meyer, Gaba & Colwell, 2005).

A second methodological approach was used in Step 4 – the 'singing' workshop – namely co-operative inquiry (CI). CI involves research *with* people rather than *on* people so all involved can work together as co-researchers and co-subjects (Reason and Heron, 1995). Validity in CO *"rests on a collaborative encounter with experience"* (Reason and Rowan, 1981) and for the purposes of co-producing the ABIF with Roma community members and professional stakeholders, taking part in a singing workshop was the 'experience'.

Singing was identified as a preferred way of engaging with the Roma population in the area during ethnographic research in Glasgow by the lead researcher (de Andrade, 2014; de Andrade, 2016). Further research suggests that Romani musicians prefer to create and engage in social discourses through the medium of music (Beissinger, 2011).
Romani musicians hold both a professional identity and a Roma identity, which is associated with low-status ethnicity. Holding these two identities helps them overcome the boundaries between themselves and the socially powerful, and engage in various ethnic and occupational relationships. This construction of identity enables them to cope with the realities of a harsh and unjust world (Beissinger, 2011). Singing was also a preferred means of engagement to overcome

language barriers. Interpreters were provided support to the smooth delivery of the workshop. These were not professional interpreters per se, but community members who are multilingual.

Step 1. Semi-structured interview with a PAR academic measuring meaningful personalised outcomes

To begin the ABIF development process, a semi-structured interview was conducted with a PAR academic, who measures meaningful personalised outcomes. Key findings are reported below summarised under key questions pertaining to the development and piloting of a co-produced ABIF.

1. **How would you capture detailed, qualitative information in a systematic way?**

Semi-structured interviews – or having meaningful conversations with participants – were emphasised as important means of qualitative data collection. The importance of paying attention to the recording of data was highlighted (for example, how do practitioners systematically record data? What is 'data' and how is it recorded?). Conversations with regulatory bodies and commissioners were also highlighted as 'data' to be linked to outcomes and policies.
It was suggested that practitioners should have a 'loose framework' with high level outcome categories at the start of engagements. Irrespective of whether organisations use scale measures, 'soft scales' or other mechanisms for capturing data, it is very important to ask the participant at the beginning and end of the interview: 'Where do you think you are now?' 'How can change happen/ How did the change happen?'

A discussion on the use of numerical scores and how they "should be used with strict caveats and not in insolation" followed. Some services note that participants or service users might also benefit from numerical scales alongside narratives. If using numerical scales, however, practitioners should "look for shifts over time instead of having a clear definition of what each score means". This allows for "an interrogation of data – what is going on with a person's changes in behaviour?"

Self-harm interventions were offered as an example. If an individual's social network scores initially go down, it is important to understand why this happened as "patients need to let go of people with whom they have damaging relationships before they build their own self-esteem and are able to reach out to new people".

Furthermore, it was suggested that practitioners should look at "patterns in changes of behaviour" and then "identify how many reviews/ contacts they need to have with patients before a change is identified". Practitioners should also use a combination of data collection techniques that are applicable in particular contexts.

2. **What is the difference between evaluating personal outcomes rather community (asset-based) outcomes?**

Trust was raised as an integral issue to both personal and collective outcomes. The need for community members to feel that they are being listened to was highlighted alongside shared understanding. It was suggested that process outcomes are evidenced in conversations about "what is going on" for participants at any stage of evaluation.

3. **How is it possible to link organisational outcomes to individual outcomes in evaluation?**

Three types of outcomes where discussed, resonating with outcomes identified in the literature review: **quality of life outcomes** (for example, maintenance outcomes), **process outcomes** (the way in which service and change happens) and **change outcomes** (more traditional outcomes such as reduction of symptoms. It was noted that in some service settings, certain outcomes might be more applicable than others. For example, people with progressive conditions might want to achieve personal outcomes rather than achieving a practical outcome (obtaining a practical skill, for example) related to coping with their condition. It was further highlighted that organisations should not prioritise organisational outcomes over outcomes that individuals identify as important. The 'Talking Points' framework, also highlighted in the literature review,

was mentioned as a useful tool to build practitioners' confidence as it gives recommendations on how to tackle multiple challenges expressed by people using services, practitioners and carers.

4. How would the co-produced ABIF framework be used by practitioners?

It was suggested that the indicator categories provided in the co-produced ABIF framework – individual, community and structural – could be evaluated through the recording of data and thematic qualitative data analysis under prospective categories. For example, recording the outcomes that individuals or communities are identifying as important to them, but the service is struggling to provide.

It was emphasised that work needs to be done around recording. For example, practitioners need to think about how to collect, analyse and record data. What is useful to be recorded? How often should data be recorded? Is there a shared understanding of what the data means to individuals and communities instead of "prescribed" definitions? Can practitioners be provided with guidance on how to look at process, improvements and continuous learning?

It was noted that it is not so important what evaluation tools practitioners are using, but how they "understand the practice". Professionals, for example, could use the co-produced ABIF template as a starting point and give community members a "structure to the encounter which will make them feel safe" without definitive interpretations in the measurement instrument. Eventually, it was suggested, practitioners might conclude that they have "succeeded in implementing the framework when the prompts are redundant". This is important to inform ABIF development. To evaluate or evidence change over time, definitive measurements are needed to track changes at the beginning, middle and end of interventions (if there is one). The ABIF is a tool that allows us to do this, and a crucial part of its implementation is its co-production with a particular group. The ABIF template provides a useful starting point, but may be adapted at baseline depending on community responses. As an asset-based initiative unfolds, communities should become familiar with their co-produced ABIF and what their identified indicators and specific definitions of each mean to them (theoretically and practically). This mean 'prompts', used at baseline to stimulate discussion and build rapport and trust between practitioners and community members, may

become redundant. This could be an indication that relationships are maturing and shared meanings are evolving.

Acknowledging and working with community members' and professionals' senses was also considered to be crucial. Capturing how people experience a sense of belonging and "success", for example, was highlighted as an important part of data collection.

Step 2. Participatory Action Research (PAR) Workshops with Professionals

Next, three PAR sessions were conducted with

- A community development organisation (n=4)
- Health Inequalities and Improvement Group (HIIG) members, Glasgow City Health and Social Care Partnership (HSCP) (n=5)
- Health Improvement leads, seniors & practitioners, (n=11)

Aim

Step 2 aided the development of the co-produced ABIF by engaging with various professional stakeholders involved in community development and health service improvement. Data was gathered through informal consultations during desk-based research (the critical literature review) and formally through PAR sessions.

The key aim was to present the evidence-based ABIF template (see *Part 1 of the report*) informed by the extensive, critical literature review and take part in an interactive session reflecting on the findings. The PAR sessions provided an opportunity for professional stakeholders to actively engage as equal partners in the project, and co-produce the ABIF.

Design

1. Ethical approval

Ethical approval was obtained from the University of Edinburgh to address the nature of involvement of participants; methods of working; data collection; data handling; and further ethical considerations. As part of the ethics application, an information sheet and consent form were developed (see *Appendix 4*).

2. Recruitment of participants

Stakeholders participating in Step 2 of the project were recruited through purposive sampling facilitated by an expert reference group. Existing networks and contacts were approached if their organisational aims related to the aims of the co-produced research.

3. Participatory Action Research (PAR) sessions

- **Introduction:** At the beginning of each PAR session, participants were given a brief overview of the project and presented with a summary of the literature review findings.
- **Discussion:** Participants received an ABIF template (see *Table 4*) with a list of the 10 key indicators identified in the literature review. Indicator definitions were left blank, as well as their impact on individual, community and structural levels. All participants were given the opportunity to express their ideas and views on different components of the framework, and their views on its implication to policy or action plans. They also reflected on their perceptions of "everyday life" for community members. Discussions on the ABIF template were structured around nine questions (see *Figure 1*). These questions were provided to guide the interactive sessions, but were not obligatory. If discussions led participants to different but related topics, these deliberations were actively encouraged. The nine questions were later used in the PAR session with community members and professionals (see Step 4) and in the ABIF guide to co-production. Following questions, however ,were not used in step 4 and in the guide :

- How do you think community members would define and / or practically 'do' these indicators?
- How would you go about measuring asset-based approaches?
- How would you show that using asset-based approaches and co-production can/cannot evidence changes in health (or other) inequalities?
- How would you practically use the framework?

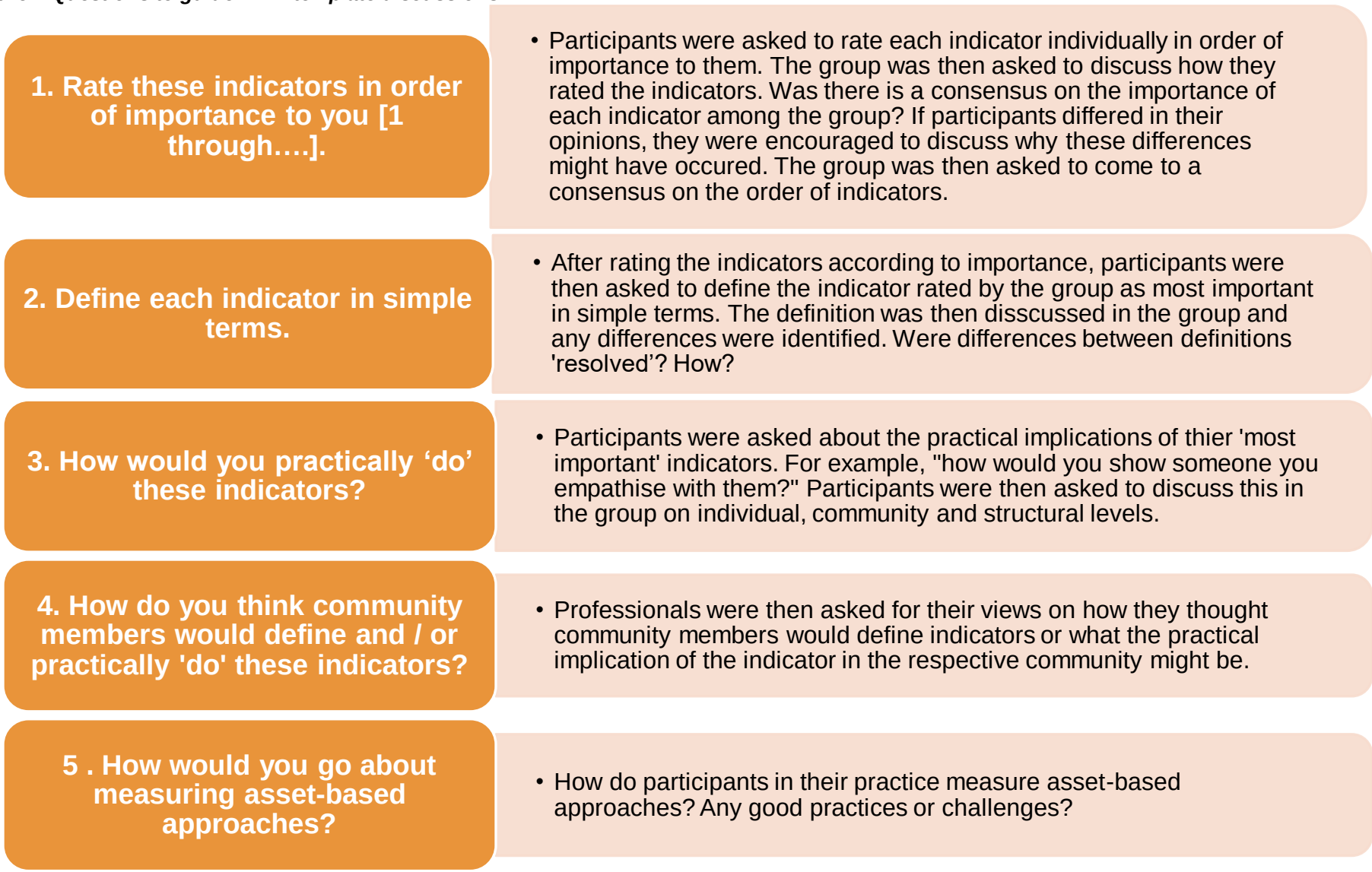
These questions are only relevant to professionals to help inform the development of the ABIF but are not relevant to community members. Therefore, the discussion guide included in the ABIF guide to co-production is an amended version of Figure 1.

The same principle has been adopted when using the questions in the PAR sessions with professionals. The group dynamic and discussions were taken into consideration and therefore some questions were missed in some PAR sessions, others were changed, or new questions were added.

Table 4 ABIF Template blank

Indicator	Definition	Individual Level	Community Level	Structural Level
Affec				
Access to resources & Healthy environments				
Culture				
Empathy				
Helpfulness				
Interpersonal Relationships				
Optimism				
Physical Health				
Self-determination				
Spirituality & Personal Meaning				
Trust				

Figure 1 Questions to guide ABIF template discussions



6. How would you show that using asset-based approaches and co-production can/cannot evidence changes in health (or other) inequalities?	• Participants were asked to think of ways in which they can find evidence that asset-based and co-production approaches work.
7. What methods would you use to engage with communities?	• Participants were asked about the methods they use to engage with communities or to provide hypothetical examples of community engagement methodologies.
8. How would you capture detailed, qualitative information in a systematic way?	• Participants were asked to share existing practices for systematic ways of capturing qualitative data. Are their any examples of good practice and challenges?
9. How would you practically use the framework?	• Participants were encouraged to think of ways they could practically use the framework in their own professional settings and what the benefits or challenges might be.

Delivery: PAR 1

Participants: 4

1-Rate these indicators in order of importance to you [1 through….]

Before rating indicators, participants first wanted clarification on whether indicators should be rated in order of importance to partcipants as *individuals*; importance in terms of *community assets*; or what might be important to *recipients of a service*. This raises interesting questions for practitioners co-producing the ABIF with different groups in future – are evidence-based indicators for health and wellbeing conceptualised differently by diverse stakeholders or community members? Do they have different meanings for these co-producers of knowledge? Should predefined indicators be provided when co-producing the ABIF with different communities?

After rating the indicators individually, participants were asked to rate the indicators in order of importance as a group. From the initial discussion, **three indicators** were rated as important for all participants**: self-determination**, which was identified as a very strong indicator; **physical health** (and more specifically the need for physical health); and **trust**, which was initially regarded as a 'broad' construct (for example, what would trust mean on an individual and community level, but also as part of social capital?). There was strong agreement among the group on the importance of self-determination, which was explained by the fact that SCDC's organisatonal aims are strongly related to empowerment of individuals.
The indicator **'Empathy and helpfulness'** was considered to be **'**not clear' as participants were not sure what it meant in this context. Some participants thought it was linked to trust. One participant asked how we might be able to differentiate between interpersonal relationships and helpfulness especially when it comes to delivery of services?

'Personal meaning and spirituality' was considered by one participant to be of low importance as spirituality was not essential to them. Personal meaning, on the other hand, was identified by

another participant as the driver of personal determination and, therefore, considered to be an important indicator. Buiding on this idea, a further participant added:
"They (the indicators) are all important. Some generate the others… And if you put the others before some of them they can go to an extreme…. they can destroy each other (no trust will destroy ideas of self-determination that promote culture).. whereas, when you have other things before, its harder then to create false… a cult…stalinism, nacism….cultures where other (indicators) are destroyed."
Participants did not have an agreed view of the meaning of **'culture'**. They suggested that it could be interpreted in different ways (for example, culture of acceptance; diversity; nationality; or even facebook). One participant added that maybe culture was not rated as highly for the group as they are Scottish residents living in Scotand. It was suggested that for minority groups residing in Scotland, culture and identity may be rated higher. This discussion illustrates how different indicator may be important for diverse groups. It also highlights how each indicator is context specific and may be expressed differently in light of external circumstances.

'Access to resources' was rated poorly by participants as they thought 'it didn't immediately make sense' to them. It was mentioned that even in a rural environment you still have access to resources, for example natural resources. It was noted, however, that people might desire other resources that they do not have. The importance of distinguishing between different resources, such as food and other physical assets, was also emphasised.

The indicator '**affect'** was rated as the least important by all participants and it was not discussed further. Several participants pointed out that they did not know exactly what was meant by the concept. Even after a definition was provided from the literature, participants noted that it was 'difficult' to contextualise.
After the initial discussion of individual indicator ratings, the group collectively agreed on rating the indicators in the following order of importance:

1. self-determination
2. physical health
3. trust

4. interpersonal relationhships
5. optimism
6. access to ressources
7. personal meaning
8. empathy
9. culture
10. affect

Participants added that the 'internal' indicators (for example, self-determination and personal meaning) might determine the 'external' (for example, access to resources).

After rating the indicators, one participant pointed out that the above ordering was largely dependent on the particular setting of the day. If, for example, the ABIF template was co-produced with a specific organisation respected for its values then perhaps indicators would be rated differently by community members – empathy might go up, depending on who you are working with. Practitioners should therefore reflect on whether indicators change their importance depending on the organisational context.

It is therefore worth considering how pracitioners may need to be flexible in their approach when co-producing the ABIF. The co-production of the ABIF and literature review recommendations suggest that it is important for practitioners to be able to understand what is important to community members . If, for example, spirituality is not important to them then the indicators should be changed or new indicators should be added. Personal outcomes approaches call for establishing meaningful conversations with communities – they should elaborate on what outcomes are important to them. This is a crucial aspect of the ABIF. When practitioners are using a potentially adapted ABIF (informed by baseline discussions), they should use it consistently. If the importance of indicators changes during the engagement, however, changes should be captured and reflected upon with the community.

Consensus around the importance of indicators was reached faster than in other PAR sessions. This could be due to the fact that the group shared similar professional values and work closely together (this was not the case in PAR 2, where participants worked across various areas). Participants also reflected on how they collectively rated self-determination first as it is aligned with their organisational values. As they predominantly work in communities and focus on wider relationships, they rated interpersonal relationships further down the scale as they perceived this to mean close relationships. The group shared the opinion that most these indicators characterise individuals and not communities.

2 – Define each indicator in simple terms. Are there differences in definitions? Why? Are they 'resolved'?

The group discussion did not result in any significant differences definitions, although there were slight nuances. For example, taking control of personal circumstances, self-directed suppor and having your voice heard, which was also linked to justice).
Despite differences in definitions, the consensus around the meaning of the indicator and its importance was reached quickly because self-determination was identified as a strong indicator by most participants.

3 – How would you practically 'do' these indicators?

Participants were asked to describe how they would evidence self-determination, as this stood out as most important to them. The examples they gave were self-directed support; having your voice heard and being acted upon; people being in control of their lives; chosing career paths; education; and community members' ability to make choices.
One of the participants emphasised that there are always limits or social costs around people's choices so other external factors have impact on self-determination. For example, having access to resources, being optimistic about one's circumstances and having sustained interpersonal relationships all contribute to one's ability to be self-determined.

Participants also agreed that indicators such as 'knowledge' and 'confidence' are missing, which emphasises the need to ask communities co-producing the ABIF if they think any meaningful indicators are absent. It is also important to understand what 'new' indicators mean to community members. In this particular case, participants did not entirely explore their motivation behind choosing this particular indicator but an interpretation can be offered if we consider that self-determination (which came out as number one indicator) is based on the knowledge and experience of people. Furthermore, as confidence develops in an individual, so too does self-determination.

It is important to note that in the literature review concepts such as 'confidence'or 'self-esteem' were identified as overlapping and were integrated into one overarching indicator, namely 'self-determination' which includes such personality characteristics in its definition.

4 – How would you go about measuring asset-based approaches?

When participants were asked whether they would use the ABIF template as a tool to evaluate asset-based approaches, they said that researchers applying it should consider the context in which it is implemented. They also emphasised that community members might not naturally consider all of these indicators and asked whether there would be flexibility when using the template.

Concerns were raised about whether organisations applying the co-produced ABIF would have the capacity to offer flexibility. For example, would public services applying asset-based approaches be willing to change how resources are distributed depending on community members' wishes even if this did not align with strategic aims? Participants added that using the language of co-production does not mean that it actually happens in practice.

It was noted that the ABIF could work if used in partnership with practitioners and communities. Structural issues related to joint working were acknowledged, but participants emphasised the importance of genuinely working together to help practitioners and policy makers understand what issues are important to communities.

There was also concern that risks might become "functional" – that asset-based approaches may patronise some communities by way of "endless positivism", while structural level inequalities persist.

5 – How would you practically illustrate the indicators at a structural level?

The following examples were provided:

- **Self-determination** – where does this fit into collective vision? Involvement at a local level; decision-making structures; community groups in the area; the ability to influence decisions through existing structures (for example, the parameters of social justice).
- **Access to ressources** – participation in budgeting.
- **Physical health** – can also be impacted on a structural level by participating in budgeting.

Participants queried the starting point for the applying the co-produced ABIF:

"When we look at the template, should we start with indicator or with the level? If we start with an indicator it becomes very broad."

It was suggested that by starting on the individual level, one might understand the motivation to change or at least challenge issues at the structural level. A further discussion focused on how the co-produced ABIF could help community members' adopt a more critical view of health.

6 – How would you practically use the framework?

Participants reflected on how a rigid framework might cause difficulties, but also gave a practical example of how it could be used in a particular setting. For example, practitioners could work with communities from Govanhill to identify their health issues at group level. With this understanding, they could work with community members to develop their self-determination –

to take control of raising issues pertaining to community health in some agreed way – and work towards improving these self-identified health issues. How could they collectively work towards achieving positive changes thereby experiencing self-determination?

Further practical examples of how professionals can tackle individual and community concerns were discussed. How do we deal with issues such as hate crime? Here it was suggested that practitioners could collaboratively explore community members' circumstances; open up pathways for getting support from each other; develop organised, community responses; become aware of and work with established networks. Systemic failures to address these issues were also mentioned.

Finally, it was noted that practitioners applying the co-produced ABIF need to establish a starting point. This would identify the change that communities want to see and, through the process of co-production, it could be possible to identify ways to illustrate how this change unfolds (or does not unfold) while asset-based initiatives are being implemented. This view implies that the proposed ABIF framework would be beneficial when used at baseline and systematically applied during and after project implementation to evidence potential change and impact.

Delivery: PAR 2

Participants: 5

1 – Rate these indicators in order of importance to you [1 through….]

Much like in PAR 1, participants in PAR 2 wanted to know how they should rate the indicators – from a personal or professional point of view. They also queried how important the difference between the personal and the professional is. More than half of the participants pointed out that individual values and attitudes influence the professional realm so it was suggested that they should not be separated. One participant added that is important to be congruent in what you do when you work with patients. Participants also referred to a further factor that may impact the

way employees see indicators, namely whether they work with the public or whether they work with staff (for example, in managerial positons).
In contrast to PAR 1, there was no match in the individual ratings of indicators in this group possibly due to the fact that participants work within different silos and have diverse roles meaning work priorities may vary. Following a negotiation process, however, the group agreed that the three most important indicators were '**interpersonal relationships'**, '**empathy'** and '**trust'.**

Participants agreed that if professionals are using asset-based approaches to evidence change in community members' lives, trust is integral. There was a further discussion around the concept of 'empathy' and its importance in the patient-professional relationship. One participant said that empathy is very important especially when working on a structural level, while another added that empathy was always useful as there is an associated emotional consequence – "a cost that professionals need to pay". It was further argued that not every person can express empathy.

This variance in viewpoints once again highlights the subjective nature of evaluation indicators. Key indicators for health and wellbeing are understood differently even for professionals working in the same organisation with the equivalent overarching strategic goals. This highlights the need for those applying the co-produced ABIF framework to allow participants to elaborate on their own understanding of indicators in specific contexts (for example, personal, community or professional).

The indicator **'optimism'** was mentioned several times as important as it helps practitioners sustain good levels of positivism in the work place. However, offering hope to people was identified as more important than optimism so it was suggested that 'hopefulness' should be added to the ABIF template. While it is worth noting that hope is implied in the definition given for optimism – 'expectations about the occurrence of good outcomes in one's future (Pinquart et al. 2007)' – terminology and indeed indicators may need to be adapted depending on participants' interpretations of particular

2 – Define 'empathy' in simple terms. Are there differences in definitions? Why? Are they 'resolved'?

Participants were asked to individually define 'empathy' as this was the indicator that generated most of the discussion. There were nuances in the definitions of empathy that participants offered (for example, the ability to connect with the pain of others and a willingness to support others). In response to the question 'How important is the definition of each indicator?' the group agreed that the ABIF needs parameters even if there are no literal definitions as this aligns to reflective practice.

A further point was the importance of negotiating meaning with communities. Participants expressed the view that it is essential for professionals to ask service users – 'what has made the difference?' and 'what is important to you?' in order for individuals to define what change means to them. It was suggested that through storytelling, communities can connect by sharing examples that have changed how they feel or who they are.

3 – How would you show that using asset-based approaches and co-production can/cannot evidence changes in health (or other) inequalities?

Participants expressed difficulties in following up on achived outcomes from asset-based intiatives. They were willing to give examples from their practice of how these approaches work, but pointed out that a lack of evaluation tools and approaches, time and resources were obstacles for following up and measuring 'soft' outcomes.

4 – How would you capture detailed, qualitative information in a systematic way?

Participants saw collective stories and "ownership of stories" as opportunities for evidencing how change happens for community members. Participants were then asked how they might be able to link communities' requests for particular changes to their own professional, organisational outcomes. This prompted a discussion on how very often change does not happen

right away and is hindered by a lack of resources thereby making it difficult to reach and evidence achieving long-term outcomes.

These two types of outcomes described by participants correspond to process outcomes (related to the participants' experiences of using a service) and quality of life outcomes (aspects of a person's whole life that they are working to achieve or maintain in partnership with services and other forms of support) identified in the literature review.

Participants said there is an existing need for services to be measuring impact in terms of change and wellbeing and *not* in terms of key targets and specific outcomes (for example, did seeing the GP over time impact the patient in terms of them not feeling lonely?). When participants were asked how they would practically capture these changes in current practices, they mentioned four key points to be considered in the evaluation of change: building relationships with the people; looking at specific ways of building trust; taking into account what conversations practitioners have with people; and working collaboratively with GP practices.

They did not, however, identify rigorous ways of capturing such data and expressed the lack of such practice in their work. The ABIF and guide to its co-production therefore offers a baseline for capturing outcomes identified as important for individuals and communities. It also serves as a mechanism for following up how these outcomes are achieved. It outcomes are not achieved, it provides evidence for the reasons why.

5 – How do you think members of the Roma population would define and / or practically 'do' these indicators?

Practitioners wanted to know why these community members want to engage. How do they perceive professionals? Are professionals engaging effectively with community members? It was further argued, that professionals will capture data in different ways depending on their roles and the communities they are engaging with.

Using creative means of engagement was identified by participants as preferable – for example, using entertaining and informative videos to capture and share community members' stories and their experiences of housing, education and physical health. Participants also said that mechanisms of engagement might be different depending on the community. They added that professionals have different roles so can have diverse conversations with community members about varying aspects of health and wellbeing. They also stressed the importance of using the following question as a starting point: 'What is the important thing for an individual?'

Practitioners also queried whether they should start with a high level indicator. If so, participants co-producing the ABIF would need to identify contributing factors and discussions around these would need to be facilitated.

It was also questioned how collaborations between professionals can be measured if services are asked to evidence that they are working in partnership with others.

6 – What sorts of methods would you use to engage with communities?

One of the participants mentioned that events for families or mothers with young children tend to be successful engagement events (for example, providing bouncing castles). Trust was raised as a pertinent issue as this would lead to opportunities to have meaningful conversations with community members in different ways through creative community engagement.

Participants said that 'trust' was linked to continual engagement so community members would know that when 'data' was collected from them (through interviews, for example), they would know why this information was being requested and what it would be used for (for example, developing a service to strengthen community assets).

7 - How would you practically use the framework?

'Social prescribing' – linking patients in primary care with community support sources – was offered as a suggestion. The group then reflected on whether applying the ABIF would add to

existing professional engagements, and wondered how it how it can be integrated into existing practices.

Delivery: PAR3

Participants: 11

1 - How would you use the framework?

This session started with questions related to the aim of the project and need for developing the ABIF. One participant expressed scepticism rating the idea at '1 out of 10' at the start of the session (this changed to 9 by the end of the PAR session). Issues such as the differences in data collection and analysis (for example, quantitative vs. qualitative data) as well as the inconsistent distribution of power and knowledge across different communities were identified as possible barriers in the implementation of the ABIF.
Furthermore, participants argued that an existing challenge for community development is that outcomes are often hard to be evidenced and that very often the political context creates austerity for community development. In relation to the identified challenges, practitioners stressed the need to allow those applying the ABIF to define indicators themselves (for example, how do community members understand access to resources and healthy environments? What is important to them in relation to this indicator?).

2- Rate these indicators in order of importance to you [1 through….]

Participants said they evaluated the indicators both from professional and individual points of view, arguing that the individual will inform the professional. One participant looked at indicators purely from an individual perspective pointing out that in asset-based working individual indicators will determine professional values.

One participant asked for further clarification on the purpose of identifying the top three indicators. A non-directive approach was adopted by the facilitator, who avoided giving clear instructions so participants could take ownership of the process.

Following group discussions, empathy and trust came up as strong indicators although some of the participants did not include them in their individual ratings. A collective decision was quickly taken to accept these as key indicators influenced by one participant's view that these two indicators are 'building blocks' for community development.

The 'second strongest' pair of indicators identified by the group were 'interpersonal relationships' and 'self-determination'. There was, however, no consensus on how important each indicator is. It was suggested that interpersonal relationships may be a predisposition for the development of self-determination. A counter argument was the view that even if an individual has meaningful and supportive interpersonal relationships, self-determination might still be an independent indicator. People with Asperger's syndrome, for example, will not view interpersonal relationships as important but for them self-determination is a driving force.

This was the first group to not make a final decision on the top three indicators, illustrating how even staff from the same group may not all agree on the importance of each asset. Capturing the negotiation processes for reaching (or not reaching) consensus as well as documenting differences in opinion is an important part of co-producing the ABIF and using it as a tool to evidence change over time.

3 – Define empathy in simple terms. Are there differences in definitions? Why? Are they 'resolved'?

There were slight differences in how participants defined empathy which did not change the meaning significantly, but reflected nuanced uses of the term. For example, one definition was 'to be aware of and respect individuals' rights, thoughts, feelings, and circumstances'; another was 'the ability to be able to consider the experiences and feelings of others and to be able to relate positively to these').

Participants said that agreeing on baseline definitions for top indicators with community members should be a priority. A discussion on process followed and the PAR facilitator raised an important point from the literature:

"The process for this [applying the ABIF] is that you don't know what you are going to get. That is the process. This is what these approaches [asset-based approaches] are all about. Abandoning the idea that you know where you are going is the starting point."

After this statement, the participant who expressed scepticism towards the use of the ABIF at the start of the PAR session commented on how their opinion was shifting in light of the framework being used in a 'non-deterministic way'. This could allow for a "real community development process" to take place.

4 – How would you practically 'do' empathy?

Individual and structural levels of the practical application of empathy were then discussed. Participants said that on an individual level, empathy could be shown through communication and validation of your feelings in verbal and non-verbal ways.

According to participants, structural level applications of empathy were difficult to define or even 'lacking from the system' (for example, the benefits system shows a lack of empathy). A discussion following on what improvements could be made on a structural level. One example was challenging structures by having a flexible system which includes empathy (for example, sickness absence was developed to include an aspect of empathy but there is no flexibility as it is very structural). In order for structural change to happen, one of the participants expressed the view that:

"The whole part of the process would be negotiating (with the community) what change would be possible"

One proposed method for engaging with communities was the use of reflective diaries for a deeper reflection about the community engagement.

5 – How would you capture detailed, qualitative information in a systematic way?

One participant shared an experience in measuring assets through 'community asset maps', which allow community members to identify what they think the assets in the community are. Personal asset maps help individuals identify their own circumstances.

To use the 'community asset map', professionals identify groups in their communities. The measurement includes a numeric scale (0-99) with which individuals identify what they take as an asset. These assets are movable depending on how individuals are feeling. Data is gathered through images, conversations and written communications.

6- How would you use the framework in your setting?

Participants thought a challenge could be if participants disengaged throughout the process. A definition provided at the start of the engagement, for example, might change if others join the community. How would these differences in meanings be negotiated? Capturing this information is indeed crucial to ABIF co-production.

Step 3. Literature review to identify "Roma communities" perceptions of framework indicators, health and wellbeing

Step 3 sought to contextualise the first application of the co-produced ABIF framework by exploring evidence from the literature on the Roma population and community members' understanding of ABIF indicators, health and wellbeing. Data was also mined from previous ethnographic research with NHSGGC conducted with Slovakian Roma and Romanian Roma community members (de Andrade, 2014). Conceptualisations of optimism, physical health, access to resources and empathy in relation to the Roma population did not appear in this literature review and are therefore excluded from the list below. While a worthwhile albeit time-consuming exercise, a literature review is not required as a step when using the ABIF with a community.

(i) Happiness

Roma often associate health with the feeling of happiness (Karlsson et al. 2013; Crondahl and Eklund 2012). They relate their happiness or sense of feeling good to a collective experience (Karlsson et al. 2013). Roma believe that thinking positively is an inherent characteristic of their community values which helps them cope with difficult situations – a trait that has sustained their survival throughout history (Karlsson et al. 2013).

Employment, for example, is perceived to be an important factor influencing improvements in their quality of life. Those who are unemployed, however, believe they still need to stay "happy" to be able to cope with their situation (Crondahl and Eklund 2012). Evidence also suggests that it is important to engage community members not only intellectually but also emotionally, in a way that provides an understanding and appreciation of their values, belief and life circumstances (Fallis 2013). For example, Romanian Roma community members reflected on the positive aspect of laughter in their lives in ethnographic research:

'When you're laughing, life is passing faster… with music, dancing, laughter… (de Andrade, 2014)

(ii) Culture

Roma culture – much like any other culture – is diverse, complex and hybrid. While the Roma population is comprised of multiple sub-groups and local clans, it is often perceived by outsiders as a monolithic whole (Atanasov 2008). There is not a recognised Roma group that can be referred to as "the one true Roma" (Hacock, 2002). Data from ethnographic research shows that classifying Roma subgroups as one (for example, not recognising the distinction between Slovakian and Romanian Roma) creates barriers and apathy between minority ethnic groups (de Andrade 2014). Some Slovakian Roma, for example, say they would not speak to Romanian Roma:

'They fight all the time [Romanians]. All they want to do is fight…'

Representatives from community organisations working with Roma communities also noted that there is antipathy between the two [Slovakian and Romanian]:

> *'There's self-ascription, but they don't want to be named as Roma – 'I'm Slovakian'. They're scared to say 'I'm Roma'. They don't want to tick that box. There's also a fear of authority. There's a problem with leaving the community if they get a job. Romani language is a sacred thing. At home, one language is spoken. A different language is spoken on the streets….'*
>
> *'There is a big difference in weight between Slovakians and Romanians'* (de Andrade 2014).

Community members, however, have managed to create boundaries between 'self' and 'others' through the means of art and music in particular) (Beissinger 2001). Music has historically been a key form of employment for Roma communities, and has also played a role in the construction

of ethnic and cultural identity. Research suggests that Romani musicians prefer to create and engage in a social discourse through the medium of music (Beissinger, 2011). In this way, they become agents in the construction of their own identity and in the making of cultural difference by manipulating social boundaries between themselves and others in order to associate themselves with the socially powerful (Beissinger, 2011). Romani musicians occupy realms of both highly skilled professionalism and low-status ethnicity which helps them create and maintain a social reality based on such discourse, engaging in diverse relationships with the various ethnic and occupational others who form their universe. This multivalent construction of identity enables them to cope with the realities of a harsh and unjust world (Beissinger, 2011).

(iii) Interpersonal Relationships

Roma perceive wellbeing to be related to the quality of family relationships, as well as the security and support that family members can provide particularly to help them cope with stressful situations (Crondahl and Eklund 2012). Roma might often see their quality of life to be dependent not on their individual situations, but on their family environments (Crondahl and Eklund 2012). With regards to relationships outside of the extended family, the preferred interpersonal relationships might be mainly with other Roma particularly when the outside society is hostile or even aggressive towards community members. Evidence also suggests that community members may be hesitant to develop interpersonal relationships with the outside community due to the belief of discrimination and rejection, as well as experience of having to build a "hidden identity" (Cleemput 2010). Within the boundaries of sub-groups, Roma organise their communities around the concept of "brotherhood" (Mayall 2015). This concept considers the ethos of sharing and connectedness of the ethnic group, which sustains a coherent social structure based on trust (Mayall 2015).

(iv) Self-determination

Self-determination (or self-reliance) was found to be an innate aspect of Roma cultural values, and has been associated with the need to maintain levels of control over community members' lives (Cleemput et al. 2007). Roma often perceive policies to be restrictive of their self-

determination, which results in the experience of high levels of stress (Cleemput et al. 2007). Two interrelated aspects of self-determination have been identified by Roma as important for the improvement of wellbeing: a nomadic form of life and the concept of "freedom" (Mayall 2015; Liegeois 1994; Cleemput et al. 2007).

Despite the fact that nomadism as a lifestyle has changed throughout time due to Roma settlement in different countries, it is still thought to be an inherited trait for the community as it is linked to a "state of mind" (Brown and Scullion 2009; Mayall 2015). Roma consider the travelling lifestyle to be beneficial for their health and wellbeing as it provides the opportunity for them to live outdoors, have 'fresh air' and be in close proximity to extended family (Cleemput et al. 2007). Moreover, the opportunity to change their settlement has been seen as a way to move away from potential danger such as hostility or discrimination by the macro society (Cleemput et al. 2007).

The travelling way is also related to the satisfaction of the need to feel free (Mayall 2015). Freedom is an important concept for Roma and has been perceived by the group to be an integral to health and wellbeing (Crondahl and Eklund 2012; Karlsson et al. 2013). Furthermore, Roma understand freedom as the ability to participate in social life on equal terms with the rest of society (Karlsson et al. 2013).

Evidence suggests that Roma often experience increased self-reliance and stoicism when they do not rely on the outside community for the satisfaction of their needs (Cleemput 2010). Roma may express reluctance in participating in activities not perceived to have an impact on their lives (Brown and Scullion 2009). However, further evidence suggests that community members tend to engage with health improvement plans if they are given the opportunity to express their own interest in what needs to be achieved, especially if they take ownership of the work in their communities (Ahmad and Naqvi 2012).

(v) Spirituality

Spirituality plays an important role in Roma culture. Community members' spiritual belief systems have often been seen by researchers as a form of adaptation to the dominant belief of the country the Roma community has settled in (Liegeois 1994). Nevertheless, it has been argued that Roma incorporate different aspects of the dominant belief systems which often contribute to the development of a syncretic spirituality (Liegeois 1994; Restrepo-Madero et al. 2016).
The belief in the supernatural has been perceived by Roma to be related to the ways they cope with stressful situations, social deprivation and discrimination (Restrepo-Madero et al. 2016). The identification with a belief system is sometimes considered by Roma as "having found a true place and meaning in life" (Atanasov 2008, p.182). However, Roma culture is also characterised by a fear of death (Restrepo-Madero et al. 2016). A fatalistic attitude is often expressed when a member of the community is diagnosed with chronic diseases or terminal illness (Cleemput et al. 2007). Roma often try to avoid any possibilities of hearing such diagnosis or even participating in events related to the discussion of terminal illnesses such as cancer. Furthermore, Roma perceive bereavement as a cause of illness and often even as a cause of death, which might further lead to grief experienced by the extended family or even by the sub-community in which they live (Cleemput et al. 2007; Restrepo-Madero et al. 2016).

(vi) Trust

The concepts of health and wellbeing are recognised by the Roma population as being collective phenomena grounded in the basic trust of family and relatives (Karlsson et al. 2013). Wellbeing is considered by Roma to be related to the experience of support and care from family, as well as to the feeling of belonging (Crondahl and Eklund 2012). The internalised traditions and cultural values are also perceived by the Roma community as protective factors against stress and experience of life difficulties (Karlsson et al. 2013).

On the other hand, Roma communities show a common distrust towards the society outside of their sub-groups because of the historical experience of discrimination and rejection (Karlsson et

al. 2013; Liegeois 1994). The lack of trust in the general community is also a result of the absence of a sense of belonging to it (Giordano and Boscoboinik 2003).

Roma's mistrust towards 'outsiders' extends to health professionals and medical staff (Cleemput 2010). Roma report experiencing negative attitudes from medical staff and a lack of understanding about their cultural values, which have led to avoidance in seeking medical help (Christine Walsh and Brigette Krieg 2007). The combination of Roma's cultural values to be responsible for taking care of their sick or elderly parents and mistrust to the outside community may result in inappropriate self-treatment and decrease in the levels of wellbeing (Cleemput 2010).

Roma's reluctance to use health services may also be related to their culture of privacy. Roma are known to celebrate their marriages in private without registering with the authorities (Engebrigtsen 2011). Furthermore, Roma often use different names when they are in private and when they present themselves in the outside community (Giordano and Boscoboinik 2003). Roma also find it difficult to discuss health related problems in mixed gender or age groups (Greenfields et al. 2014), and may wish to remain anonymous when they are included in research (Ahmad and Naqvi 2012).

Ethnographic research suggests that Romanian Roma are generally mistrusting, but build relationships with community organisations over time:

> *'… there is a deep mistrust of the state… I don't think they will trust the state, but they will trust community organisations who are giving them things. So there is a bit of a trade-off, but I think it's kind of like the organisations build up the links with the community…' (representative from community organisation)*

'… [Romanian Roma] don't trust social worker but trust health visitor… social workers are synonymous with taking away their kids…' (de Andrade 2014).

Step 4. PAR and Singing Workshop with Roma Community Members and Professionals

Aim

During Step 4, a PAR session was conducted with community members so they too could be equal and active partners in the development of the co-produced ABIF. The idea was to compare and contrast evidence from the literature review about community members' understanding of framework indicators, health and wellbeing.

Professional stakeholders who took part in Step 2 were also invited to this seven-hour workshop, as they expressed an interest in engaging with the Roma community without a predetermined agenda. They simply wanted to hear what is important for community members; learn more about the reality of community members' lives; understand what 'health' and 'wellbeing' means to these community members; and have open exchanges about how services could be adapted and improved to make them more culturally suitable.

The singing workshop therefore created an opportunity for professional stakeholders and community members to learn from each other while co-producing the ABIF. The event was filmed to facilitate data collection and also knowledge exchange.

Design

1. Ethical approval

A further ethics application was submitted for Step 4 of the testing of the co-produced ABIF. Information sheets and consent forms were adapted for community members (see *Appendix 3*).

2. Recruitment of participants

Community participants were recruited through existing contacts and local champions in the lead researcher's professional network including the Romanet Multi Agency group. This group was

originally the Romanet Health & Social Care working group with a wide membership including health, education, social work, housing (Govanhill Housing Association), the Police, DRS, Jobs and Business Glasgow, and many 3rd sector organisations in Glasgow.

3. PAR 'Singing' session

The workshop was delivered over one day (seven hours).

- **Introduction:** The workshop started with a short 'singing', ice-breaker exercise so participants could get to know each other and feel they were in a safe environment where they could express their views and opinions. The ice-breaker also served to develop trust between community members and professionals. Warm-up songs and exercies prompted community members to start thinking about 'health' and 'wellbeing' and what these concepts mean to them as individuals as well as in their communities. There was an opportunity to share what music means to each of the communities present.

- **PAR session:** Participants were then split into three groups with a mix of community members and professional stakeholders. Each group was allocated a person who could translate from or to the native language of Roma participants (for example, Slovakian or Romanian) for language barriers to be overcome. Each group received enlarged copies of the ABIF template, cards with each of the indicators, blank sheets of large paper and coloured pens for creative brainstorming sessions. A PAR session was conducted guided by the questions in Figure 1. After lunch, all three groups came together for a collective discussions to share findings and compare and contrast outcomes, definitions, views and ideas.

- **Song production:** Participants were split then split into two, different groups with a mix of community members and other stakeholders. Each group was asked to produce a song around topics discussed in the PAR session. After composing the songs, groups performed to each other.

- **Evaluation:** The day ended up with a short discussion about the produced; potential ways to work together using asset-based approaches; and with an evaluation. To make the process of evaluation more creative, participants were asked to write or draw on enlarged sheets of paper with pictures of human-sized bodies. Three questions were asked referring to different parts of the body:

  - **Head:** 'What new knowledge do you have now?'/ 'What knowledge did you gain?'
  - **Hand** 'What new skills do you have now?'/ 'What skills did you gain?'
  - **Heart**: 'What are you feeling now?'/ 'What are you passionate about after the workshop?'

These questions provide a mechanism for drawing out and organising knowledge at both personal and community levels.

Community members were then asked to provide a "wish list" for what they would like to happen next for them in relation to community engagement and their health and wellbeing.

Professional stakeholders also received evaluation questionnaires (see *Appendix 5*).

Delivery

20 Roma community members, who self-identified as Czech Roma, Romanian Roma, Polish Roma and/or gypsies, attended the creative community engagement event. They heard about the day through local champions, who spread the word. Community members received a £20 incentive voucher.

Nine professional stakeholders from Glasgow City HSPC. Several professional singers from the Roma community, a couple of guitarists, an accordionist and percussionist. Some community members helped with translations when language was a barrier.

(i) Getting to know each other through singing

The exercise was facilitated by a professional Scottish singer. Participants were invited to introduce themselves through a creative singing exercise where every participant had to 'sing' their name. The exercise sought to create a creatively charged atmosphere – one where participants felt comfortable to share their own personal stories in a safe and trusting environment.

A short discussion followed about the importance of singing for Roma and Scottish people. Roma community members saw music as a means to express love, grief, friendship and joy. The singing facilitator introduced a Scottish song and the community members shared a Roma song. This allowed participant from both cultural groups to explore what differences, but also what similarities there are between the two songs. The melody from the Romani song was used in the 'song writing' part of the workshop.

(ii) Co-producing the ABIF: PAR with Roma community members and professional stakeholders

Participants were then split into 3 small groups comprised of a mix of community members and professional stakeholders. Firstly, participants were asked to define each of the 10 indicators. After defining the indicators, participants were asked to reach a consensus in their group and rate the indicators of importance to them. Each group was then shared their 'top three' indicators to elaborate on how participants understand these three indicators.
Data for definitions of each indicator was gathered on flipcharts produced by participants noting their thoughts and ideas (see findings in Table 2). Although definitions were only sought at the community level, community members spoke about these indicators at individual and structural levels too. Large group discussions, participant observation and the sharing of stories created the opportunity for others to hear different perspectives and dialogue between professionals and community members.

Indicator	**Group 1**	**Group 2**	**Group 3**
Affect	Initially, there was confusion about the meaning and definition of this concept across all three groups.		
Access to resources & healthiness of environments	- People know where to go for help - Church services - Good access to health services	- Internet, access to information - Being able to be connected with your community and family - Transport - Access to water - Democracy - Education - Access to housing - Translation - Difficulties might be language and lack of employment	- Education and money - Health – long waiting lists for appointments - Barriers to access health services (feel that it needs to be an emergency before you can see someone) - Concern over healthcare for children (a mother knows her child and doctors can sometimes think differently) - Drop-ins vs. appointments
Culture	- Traditional dress can be an expression of women's status (long skirts are a	- It shows where you are from - Traditions (food,	- Identity - Individuality - Tradition

	symbol of women's modesty) - Traditional clothing related to respect for older people	music, dance) - Language - Religion - Different clothes - Different values	- Family growing - Misunderstanding between communities - Learning from each other - Remembering historical circumstances - Focus on positive sides of culture instead of negative - Labels - Connection between cultures (common ground)
Empathy & helpfulness	- Importance of (extended) family	- Good feeling to help - Satisfied - Others understanding your feelings - Respect for each other - Trust - Accept others' problems and help them to resolve	- Helping each other – supporting/ protecting - Family and strangers – help someone on the street, we are all equal. - Charity work (Mary's meals) - Volunteering - Experiencing help in

			Scotland in getting work, homes, schooling - Accepting different cultures
Interpersonal relationships	- Family - Gypsy community	- Stability (coping with ups and downs) - Trust - Help, support - Resilience - Family, friends - Good feeling, not being lonely - Respect - Loyalty - Success - Being connected - Being in control - Can be heart breaking (jealousy)	- Respect for elders (‘elders in Scotland are lonely’) - It is important to have relationships - Having a close family means that people are not isolated - Care in family instead of care homes - Finding support in the family - Giving back to older generations - Responsibility vs. Individuality - Money vs. Relationships

			- 'Family members have worked hard for us so we look after them' - Family is very important in Roma culture (would not travel alone but with whole family; big families)
Optimism	- Feel safer here [Scotland] – still stereotypes but more tolerant - Some hope but feeling worried about Brexit and the possibility of being sent back [to the country of origin]; Home is here [Scotland] - Optimistic about Scotland - Less stress and discrimination -	- Being open, happy and positive - Having dreams - Having a 'can do' attitude - Easy life - Coping better - Confidence	- Moving to another country for a better life - Overcoming barriers

Physical health	- Access health	- Being fit and active - Being healthy - No need to see the doctor - Feeling good - No pain - Being able to work - Fulfil dreams - Independent	- Fast food in Scotland - Polish people are healthier - try to cook every day
Self-determination	This indicator was not discussed in all individual groups. In the group discussion, it was defined as having a dream and being in control.		
Spirituality and personal meaning	- Belief in God – important in daily life - Going to church	- Belief in something (for example money) and having a purpose (success) - Belief in God or something above us and not being able to take control - Different faiths - Church or other venues	- Spirituality is personal - Without spirituality there is no trust and love - Religion – family growing - Respecting beliefs – trust between people

		- History - Believing and being yourself	
Trust	- Relationships need trust - Connection to the wider community - People can trust each other when in need – human rights.	- Trust in relationships or friendships - Not to worry - Feeling comfortable - Relying - Support - Help - Honesty - Loyal - Keep a secret	- Trust in society and people - Safety - Being open with each other - Equality

Rating of Indicators	*Group 1*	*Group 2*	*Group 3*
'Top three'	**1. Physical health** **2. Access to resources and healthiness of environment** **3. Trust**	**1. Trust** **2. Self-determination** **3. Interpersonal Relationships**	**1. Trust** **2. Culture** **3. Interpersonal Relationships**
	4. Empathy and helpfulness 5. Culture 6. Optimism 7. Affect 8. Interpersonal	4. Affect 5. Empathy and Helpfulness 6. Optimism 7. Culture 8. Physical health	4. Physical health 5. Empathy and Helpfulness **6. Optimism / Self-determination** 7. Access to resources and healthiness of

	relationships 9. Self-determination 10. Spirituality and Personal Meaning	9. Spirituality and Personal Meaning 10. Access to resources and healthiness of environment	environment 8. Affect ***Spirituality and Personal Meaning-*** important for some participants but not so much for others

Affect and Self-determination were not defined by Group 1 and 3. Affect was mainly understood as 'effect' by group participants. Group 2 asked the researcher for the definition of 'affect' identified by the literature review and only then community members found it easier to understand. Interestingly, only Group 2 rated affect at position 4. For the other two groups affect was not a significant indicator (positions 7 and 8).

This suggests that predefined indicators may be misunderstood by community members if they use the terms differently. When they are provided with definitions, however, they may find it easier to relate the indicator to their community contexts and to rate them accordingly.

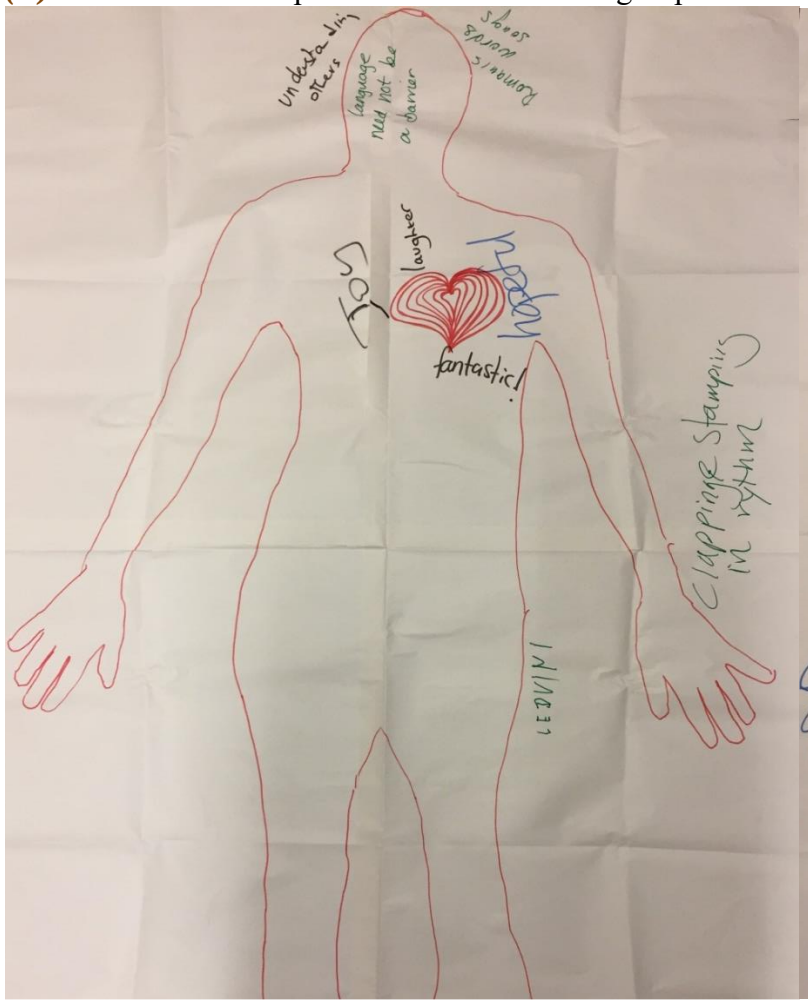
(iii) Song writing and singing together

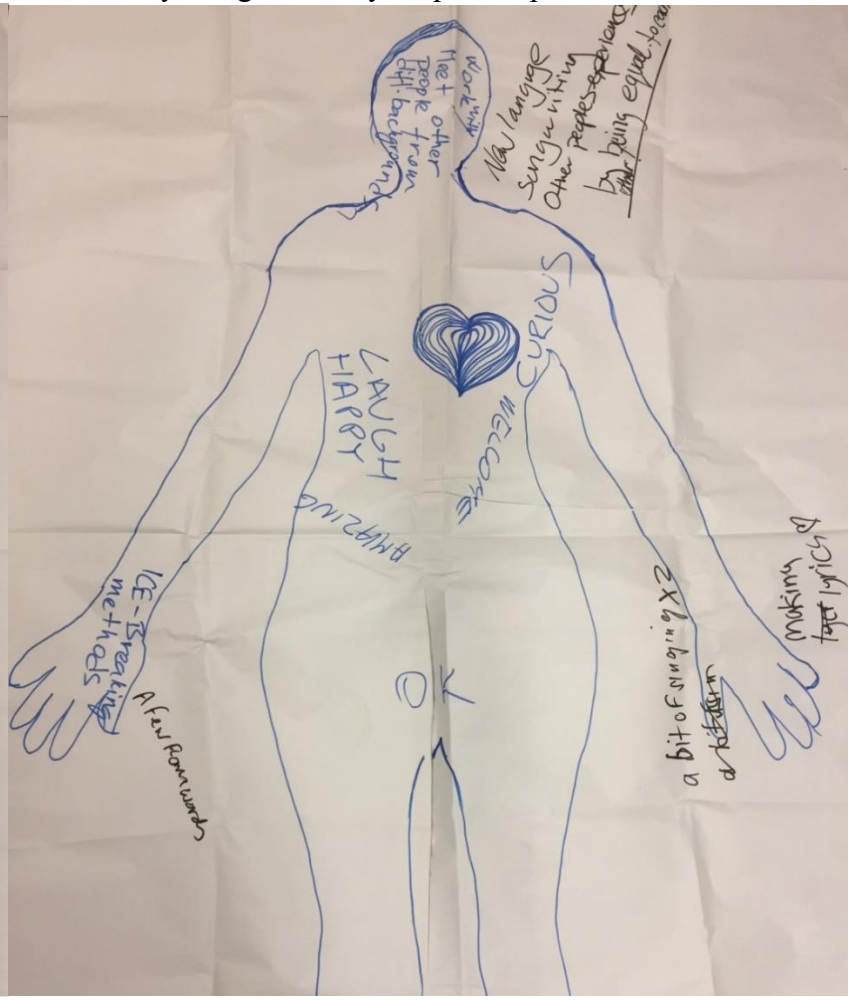
Participants were split into two groups and were asked to each write a song using the melody of the song from the warm-up exercise. Each group included professional Roma singers, as well as professional stakeholders. One of the groups decided to write the song both in English and Romani, while the other group used only Romani but translated the song into English. After writing the song each group sang their song in front of the others. The lyrics of the two songs are as follows:

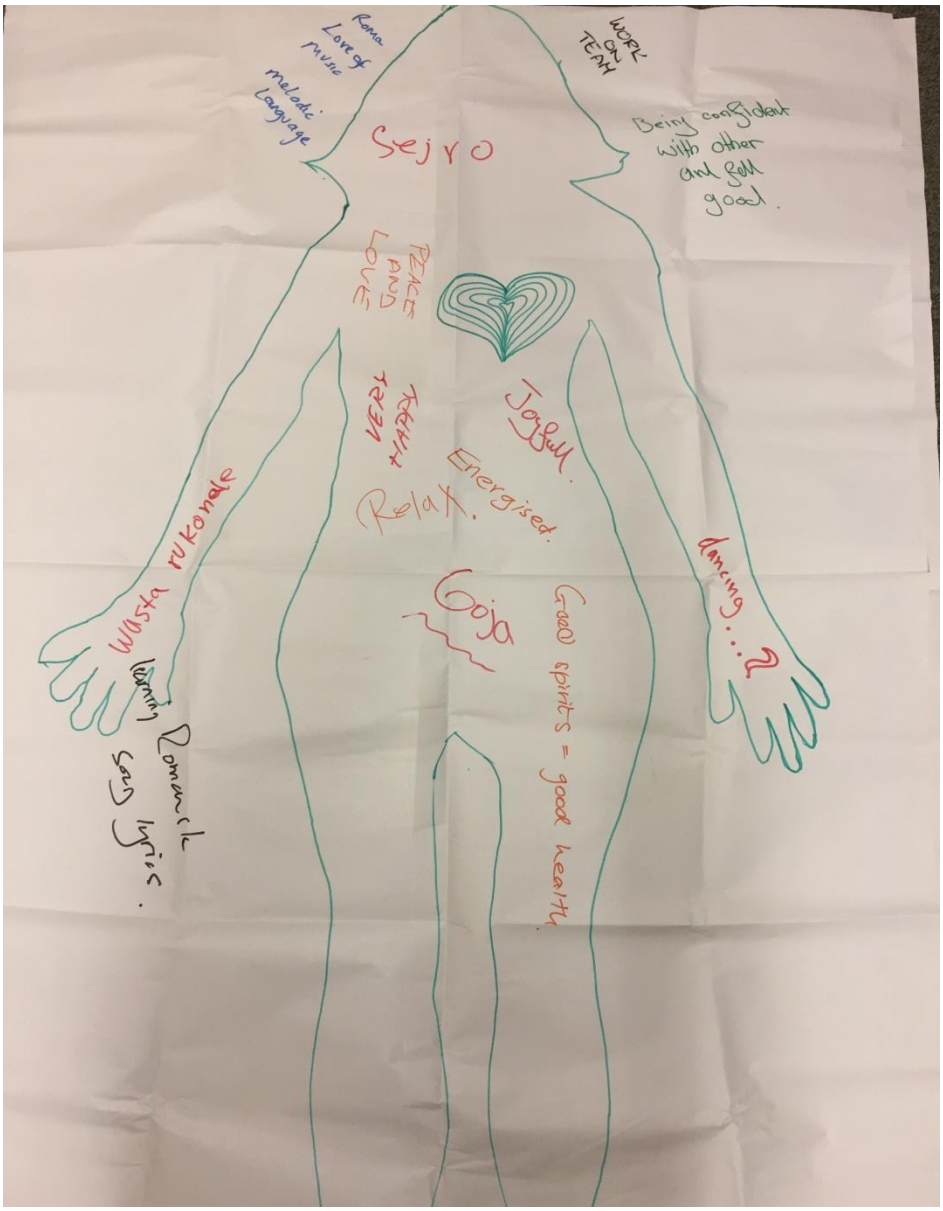
Group 1	Group 2	
We are the Milano crew	Savre roma samkate	All Roma are here
We are gonna sing to you	Andro Glasgow bashavas	In Glasgow were playing
We are sharing love and piece	O chavore amenza	The kids with us
And we trust you	Gilaven	Singing
Chorus	*Chorus*	*Chorus*
Su nen man	Sam saste	We are very
Su nen man	Te bachtale	Healthy and happy
Romanes gadikanes	Aopkure von kelen	

Adaj amen araklam	Shukar voja vonkeren	
Kaj o gila te thowas	O chave von bashaven	The kids are playing
Gadikanes Romanes	Gilaven	Singing
Gilawas		
	Chorus	
Chorus		
	Savore sam saste	
	Kajse sam barikane	Everyone is healthy
	Te dzidzuvas ame	We are all happy
	Ketane	So we live
		Together

(iv) Evaluation Participants were asked to do a group evaluation of the day using the 'body shape' templates.






Roma
Love of
music
melodic
language
WORK
ON
TEAM
Being confident
with other
and feel
good.
PEACE
AND
LOVE
Joyful.
Energised.
good spirits = good health.
dancing...?
Wasta rukonde
learning Romantic
song lyrics.

(iv) Wish list: what would you like to happen next for you in relation to community engagement and your health and wellbeing?

The wish lists produced by community members included following points:

- No judgement
- No racism
- Respect differences
- Be good to others, help others
- Free gym access
- Education for all Roma people
- Christmas and New Year's party for all Roma

(v) Professional stakeholder evaluation

1. **What did you learn about community's perceptions of health and wellbeing after participating in the workshop?**

Professionals identified the importance of health and wellbeing for the Roma community. One evaluation form pointed out:

Being healthy is 'everything' [for Roma people].

Professionals, furthermore, emphasised the importance that community members place on relationships, trust and family values leading to good health. One evaluation form mentioned that community members see health very closely linked to happiness. With regards to the barriers that community members experience when trying to access health services, one evaluation form recognised that bad experiences in healthcare lead to community members trusting health practitioners. Negative experiences at the job centre and language were identified as further barriers for building trust. One professional did not realise the extent of the barriers faced by Roma communities when trying to access health services.

2. **What does this tell you about ways to evaluate health and wellbeing of communities?**

Engagement with communities through fun activities, arts and initiatives that are of interest to them were recognised as necessary alongside 'traditional' evaluation methods such as surveys. Traditional methods were described as *'not useful when trying to evaluate the health and wellbeing of the Roma community.'* Creative approaches for evaluation, however, were described as *'practical and fun way[s] of linking and staying connected'*. It was also emphasised that professionals need to *'capture how people feel'* about different indicators and consider the importance of the implication of each indicator on community and individual levels. Regular interactions with the community, communication and sharing were identified as integral to the evaluation process. One professional pointed out that community engagement is not consistent enough and that neighbourhood approach can be a helpful method for engagement.

3. **What is your own perception about health and wellbeing and did it change (how?) after your participation in the workshop?**

Most professionals did not change their perceptions of health and wellbeing. Only one professional wrote:

'I realised that happiness and wellbeing are based on friendships, relationships, and family above all.'

Another professional stated:

'My perception of health did not change but my understanding of the values within this group changed. I now have a greater understanding of what really matters in their opinions.'

4. **What would you do next time when you engage with communities?**

Professionals said they wanted to use *'asset-based approaches and community champions'* as well as *'art workshops'* to *'try to understand their [community members'] points of view more.'* They expressed a desire to *'be more aware of the lack of trust between the Roma community and*

health professionals and do more to develop relationships and build rapport'. As several community members had young children and could not afford childcare, one practitioner highlighted the need to *'ensure that facilities are available for children'* when using creative community engagements to collect data. The need to *'be more aware of cultural importance'* was also raised.

Professionals said they *'enjoyed singing and working with people'*. One added: *'I found the day very helpful and enjoyed embracing a different culture – if only more NHS employees could have a similar experience! They might understand the community better and know how to engage with them better.'* They reflected on how *'team work was great'.*

In terms of thinking critically about future asset-based initiatives with these communities and using the ABIF for evaluation purposes, it was noted that *'some of the indicators and their meaning got lost in translation and were difficult for Roma people to conceptualise'* and group members who were not from the community may have had their own *"agenda"* which *"influence the group'.*

Step 5. Semi-structured interview with a practitioner working with the gypsy/traveller community

As community members in the singing workshops self-identified as gypsies, a semi-structured interview on the ABIF indicators was then conducted with a practitioner working with the gypsy/traveller community. The idea here was to find out more about this particular community to account for differences or similarities in perceptions of health and wellbeing, and anticipated indicator definitions.

It was noted that most gypsy/traveller community members do not identify as 'Roma' and were born in the UK. While the perception tends to be that practitioners cannot provide services as these community members are constantly on the move, it was noted that several gypsies are settled either in housing on sites.

Travelling in this community is linked to the aspiration to have ***freedom***, which is associated with improved health and wellbeing. Several community members experience difficulties in articulating how they feel about living in houses and express fear of the reaction they might get when disclosing their identity when accessing services. It was noted that gypsy/travellers often feel that they are 'trapped in a house'.

The ***right to basic minimum standards*** for every tenant living on a site was highlighted as an issue that all community members would agree should exist to improve health and wellbeing. Improvements in this community's living conditions is therefore a clear baseline measure that could be captured if the ABIF was to be co-produced and applied with this particular group.

For gypsy/travellers, ***trust*** exists within a community. Recruitment for a creative community engagement therefore happens through individuals in the community and not through flyers. The importance of engaging with several different community members was highlighted so people feel they are all included. Other suggested baseline measures included community members building pride in themselves and a renewed interest in some of the ways people look at their mental health.

Spirituality was highlighted as important for some community members. This was also linked to the community's relationship with the land and the work that community members initially engaged with such as recycling.

According to this practitioner, there is frustration over how little control community members feel they have over their own lives. For example, an inability to travel and no control over their neighbours when living on a site. These issues were linked to ***self-determination***. It was suggested that changes in this indicator could be practically measured by gypsy/travellers' openly disclosing their identities as several choose not to as they fear the consequences.

While it was noted that the community has generally pessimistic outlook, adaptability and flexibility were identified as community assets. A ***lack of optimism*** was linked to an inability to

go back to a traditional way of life, not being listened to, and not seeing changes that would impact their health and wellbeing at a structural level despite ongoing consultations and policies. Interpersonal relationships with family were identified as important to this community.

Professional relationships, on the other hand, were often hampered by a lack of trust. It was suggested that experience ***empathy*** and getting help from professionals would improve relationships over time and reduce mistrust

A nomadic lifestyle was identified as central to the ***culture*** of this community in terms of culture – even if most community members have sedentary ways of life now, there is an aspiration to be on the move. The roles of different genders, specific beliefs about hygiene, where community members physically live, language, ancestry, particular terminology used for family members, respect for elders and expectations you have of children (for example, when does a child become an adult?) were also highlighted as cultural specific community traits.

It was suggested that a measure for evidencing changes in access of resources and healthiness of environment could be monitoring community members' awareness of health issues and awareness of health improvement services that are available to them.

Step 6. Consolidation of findings to present the co-produced ABIF framework

Piloting the co-produced ABIF with the Roma community in this way has proven that it is feasible to engage and collect data from even the most socially excluded communities.

During the process of co-production, professional stakeholders were asked why they wanted to engage with the Roma community. Did they have a particular question in mind? Professionals replied that they simply wanted to engage – to have the opportunity to meet with community members, find out more about what is important to them in relation to their health and wellbeing, to build trust and start building relationships with these communities.

The singing workshop – creative community engagement – provided an opportunity for this happen. As creative brainstorming around the ABIF template unfolded, practitioners came to understand more about this particular community.

This creative community engagement event also served as a 'baseline' measure to gather information about 'who?', 'why?', 'what?' and 'how?' to use asset-based approaches with this particular group to evidence changes in health, wellbeing and inequalities over time. Any further engagement with community members would then capture changes in these baseline measures.

Key learnings and their implications using the ABIF to capture changes in health, wellbeing and inequalities with this community are highlighted below:

- There is no such thing as a 'Roma community'. In this creative community engagement day alone, there were Czech, Polish and Romanian Roma. Some also self-identified as gypsies.

Who are you engaging with? Any future creative community engagement with this particular group would have to clearly acknowledge diversity. This is crucial for evaluation purposes. Alternatively, practitioners could engage with sub-groups separately in different ways if they wanted to evidence changes in one particular sub-group over time. How they do this would need to be negotiated with that particular sub-group.

- The singing workshop with this community was used to simply start the process of engagement and relationship building, and gather data on health and wellbeing. It was also used to pilot the feasibility of co-producing the ABIF with a socially excluded group.

Why are you engaging? Future engagements with this community may be for a different reasons. Now that baseline data has been gathered, a particular intervention or health priority may emerge. Using the co-produced ABIF, for example, you may want to measure changes in trust ('being open with each other') through continuous creative community engagement to see if/how they are linked to improved health outcomes. Do these engagements signpost community members to particular health improvement services? If so, are community members supported by relationships nurtured through creative community engagement and encouraged to keep going to smoking cessation clinics, for example? Does this lead to them quitting smoking?

- The singing workshop was used as a means of engagement for co-producing the ABIF as this is what community members asked for.

What are you going to do with the community? It may therefore be appropriate for future creative community engagements with this community to be focused on music, but is up to practitioners to negotiate this with the community.

- Data from this particular engagement was captured through flipcharts with pictures and words. One research also took notes throughout the process, which included reflections from observations. The day was also filmed to facilitate data collection.

How are you capturing data? For other groups, this may not be the best way forward. Perhaps questionnaires or interviews would be more appropriate. Practitioners are also encouraged to keep reflexive diaries so they too can capture the granularity of sensory data.

- After applying the co-produced ABIF with this community, we now have baseline data that can be linked to three types of outcomes:

- **Process outcomes**: related to communities experiences of using a service
- **Change outcomes:** refers to the improvements that community members are seeking.
- **Quality of life outcomes:** include features of a person's whole life that they are working towards achieving or maintaining in partnership with services and other forms of support.

Examples of outcomes from this creative community engagement:

- **Process outcomes**: practitioners understanding your feelings; feeling respected by professionals; no stigma (racism)
- **Change outcomes:** access to free gyms, housing and health services
- **Quality of life outcomes:** less stress and discrimination; coping better

- Finally, practitioners should link these outcomes to local, national and international policies or action plans. Examples are provided below.

Local	**<u>Health inequalities agenda at Glasgow City HSCP</u>** - Use the ABIF to evidence changes in access to healthcare services facilitated through creative community engagement. For example, community members can be signposted to Smokefree Services, which contribute to the reduction of health inequalities through the prevention of poor health for those most at risk and by promoting equality of access to and outcomes from service provision. This is also reflected in the LDP Standard which measures successful smoking quits at in the 40 per cent most deprived SIMD areas. Use the ABIF to design and deliver targeted interventions within nine identified 'neighbourhood areas'. **<u>Glasgow City HSCP Strategic Plan</u>** - Use the ABIF to evidence change linked to emerging priorities for the three localities that are responding to local needs and issues. - Use the ABIF to work with partner agencies and community members to meet specific needs in the Govanhill area (including housing) and the significant Roma population Use the ABIF to continue to deliver smoking cessation work with the local BME population.
National	**<u>The Equality Act (2010)</u>** - Use the ABIF to measure changes in equality over time and understand why/why not these changes are occuring. Community members explicitly raised racism and stigma at baseline. - Included in the Equality Act (2010), is a requirement on all public bodies to consider the impact of policies and services on the needs of individuals with 'protected characteristics' (age, disability status, ethnicity, gender/sex, religion/belief, sexual orientation and gender identity). All health improvement /services/topics & contracted services now collect (or are working towards) 'protected characteristics' information on people they engage with and is held in a shared database. By doing so it helps with understanding the characteristics of an individual to improve individual care and support at the point of service delivery and recording information about personal characteristics can help to plan services that are accessible and beneficial to all.

	- Use the ABIF to evidence outcomes linked to Scottish Government Wellbeing Outcomes.
International	**<u>UN Sustainable Development Goals (SDGs)</u>** - Use ABIF data to link to SDGs such as Goal 10: Reduce inequality within and among countries.

7.2. Summary

This section presented the co-production of ABIF and its inaugural application with Roma/Gypsy community members from Glasgow's South Side.

The next section will present a guide to co-production of ABIF for practitioners. The guide will present the journey of co-producing the ABIF and how it can be used as an evaluation tool, the lessons from the pilot and the application of ABIF in other contexts.

8. The Asset-Based Indicator Framework (ABIF): a Guide to Co-Production

8.1. Introduction

The ABIF captures and measures changes in health, wellbeing and inequalities through creative community engagement.

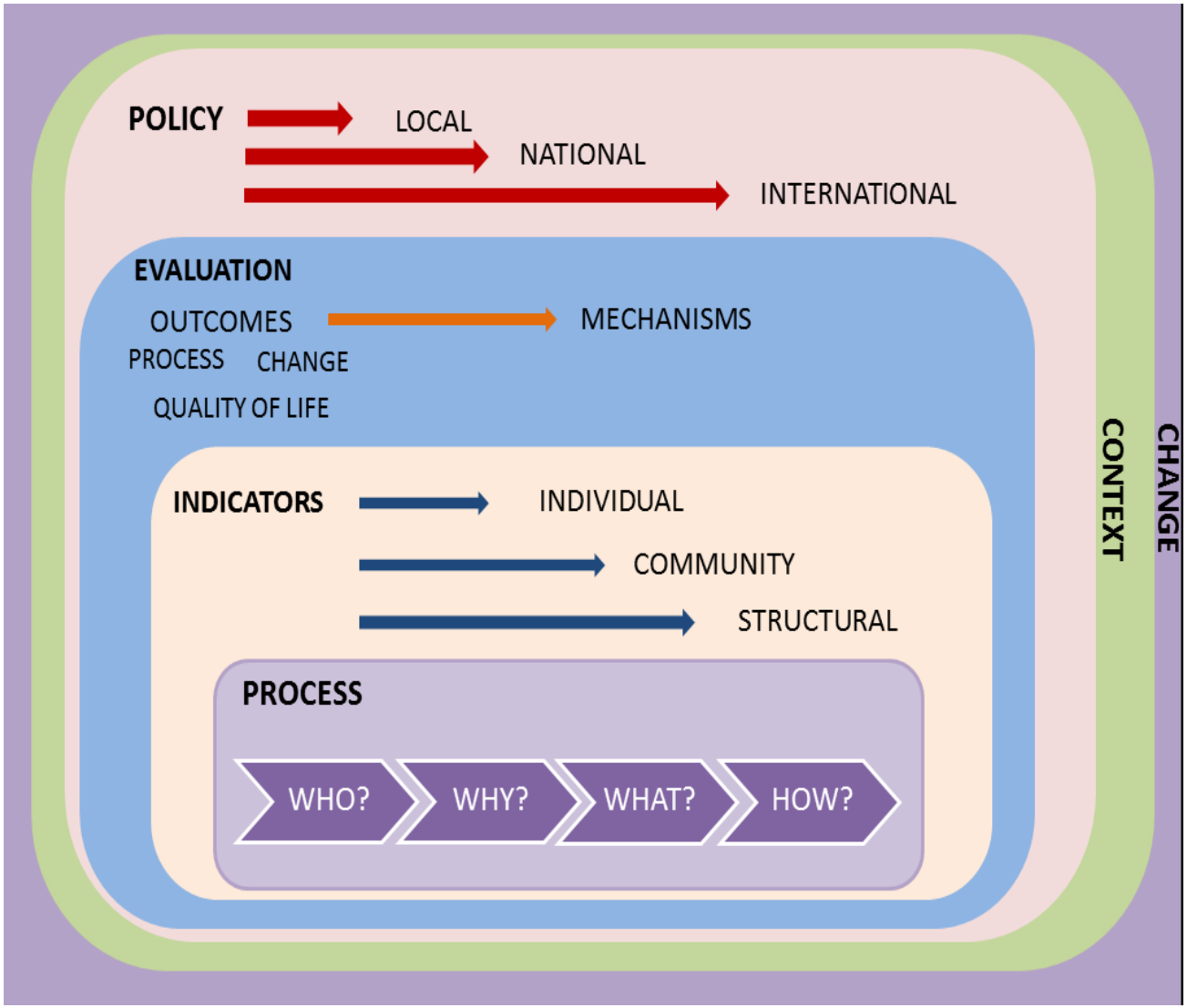
If used systematically and continuously, the ABIF serves as a mechanism:

- for capturing "softer" outcomes inherent in asset-based working alongside traditional targets and measures.
- link these outcomes to local, national and international targets and outcomes.
- for evidencing changes (if any) in health, wellbeing and equity linked to asset-based work over time.

- for monitoring the effectiveness of asset-based work to engage service users and co-produce services.
- which can be used across topics and services (Health & Social Care Partnership and other partners) to monitor and account for asset-based activity.

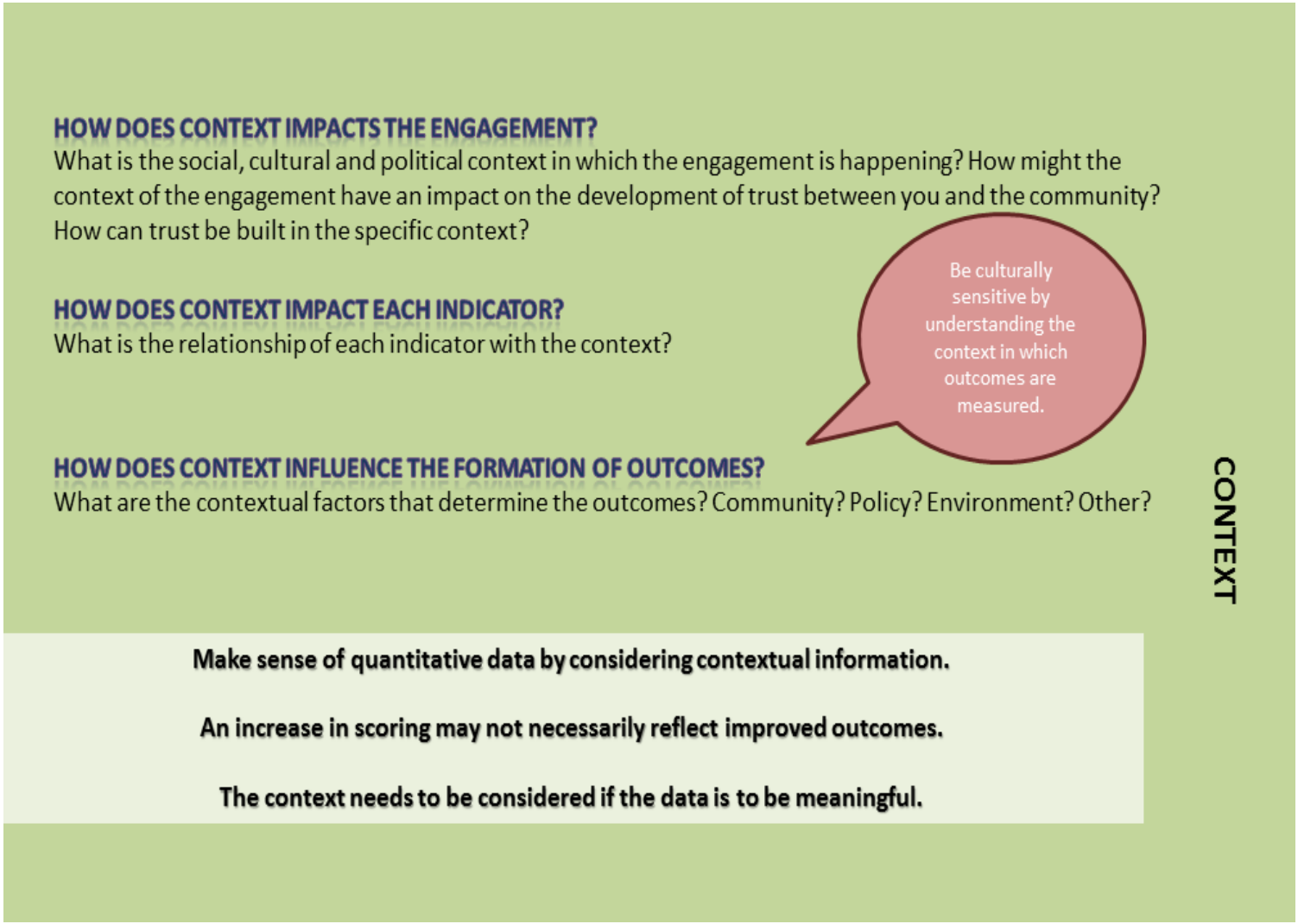
To measure changes in health and inequalities through creative community engagements, we need to understand the context of the asset-based intervention, activity or programme. Without context, the data collected is meaningless and changes cannot be measured. Context is linked to the policy environment – local, national and international policies, plans and priorities need to be considered. Changes evidenced using the ABIF can then be linked to local, national and international outcomes. Communities are clearly impacted by the policy environment and structural issues. The ABIF is co-produced with communities. As communities are comprised of community members, the ABIF captures changes at individual and community levels. It also captures changes at the structural level. As an evaluation tool, the ABIF captures process, change and quality of life outcomes.

The journey of co-producing the ABIF and how it can be used as an evaluation tool can be summarised in the diagramme below.



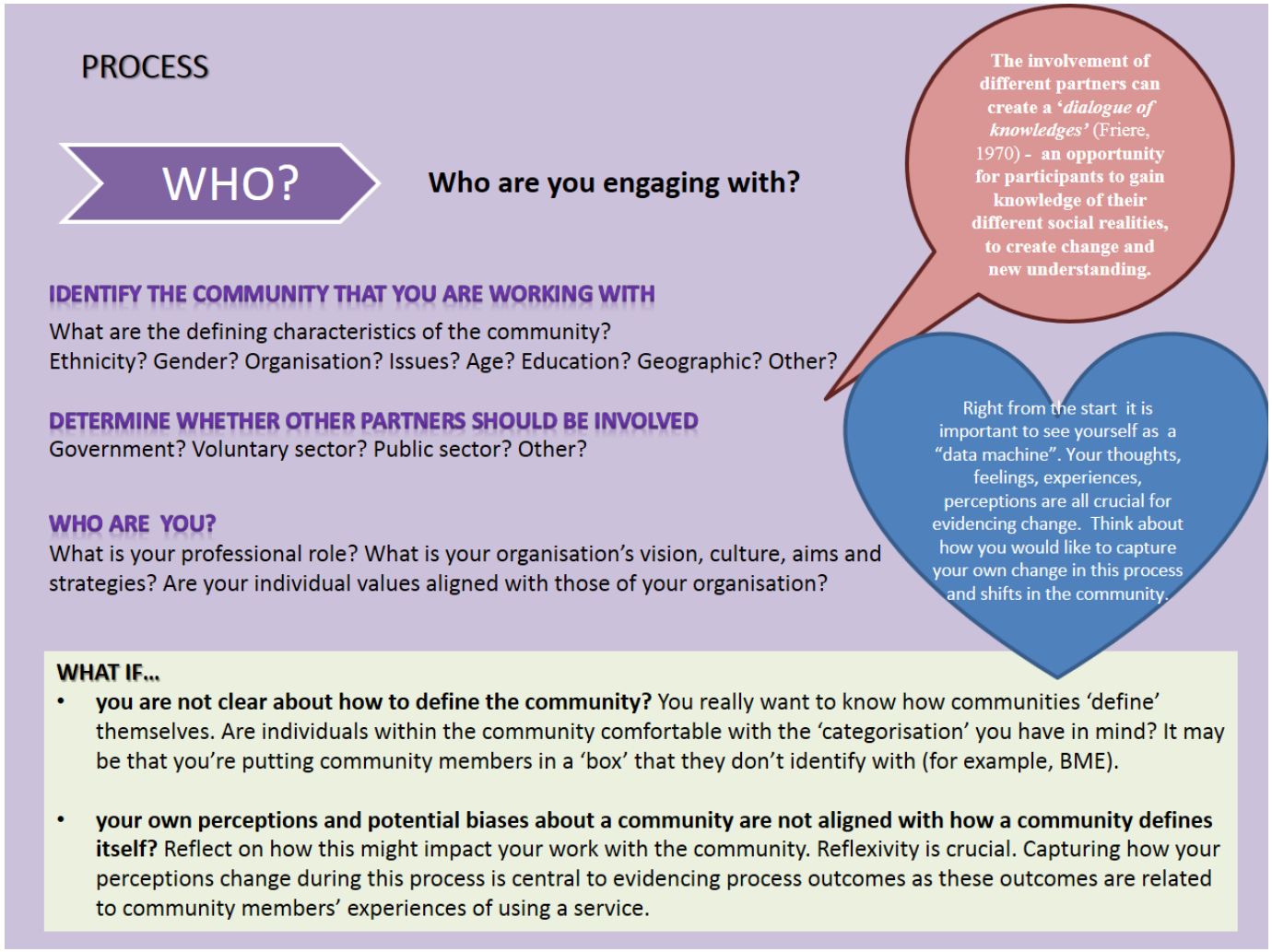
8.2. Application of ABIF

The first level of ABIF application refers to identifying the context in which the engagement takes place and how the context impacts the engagement and can impact change.

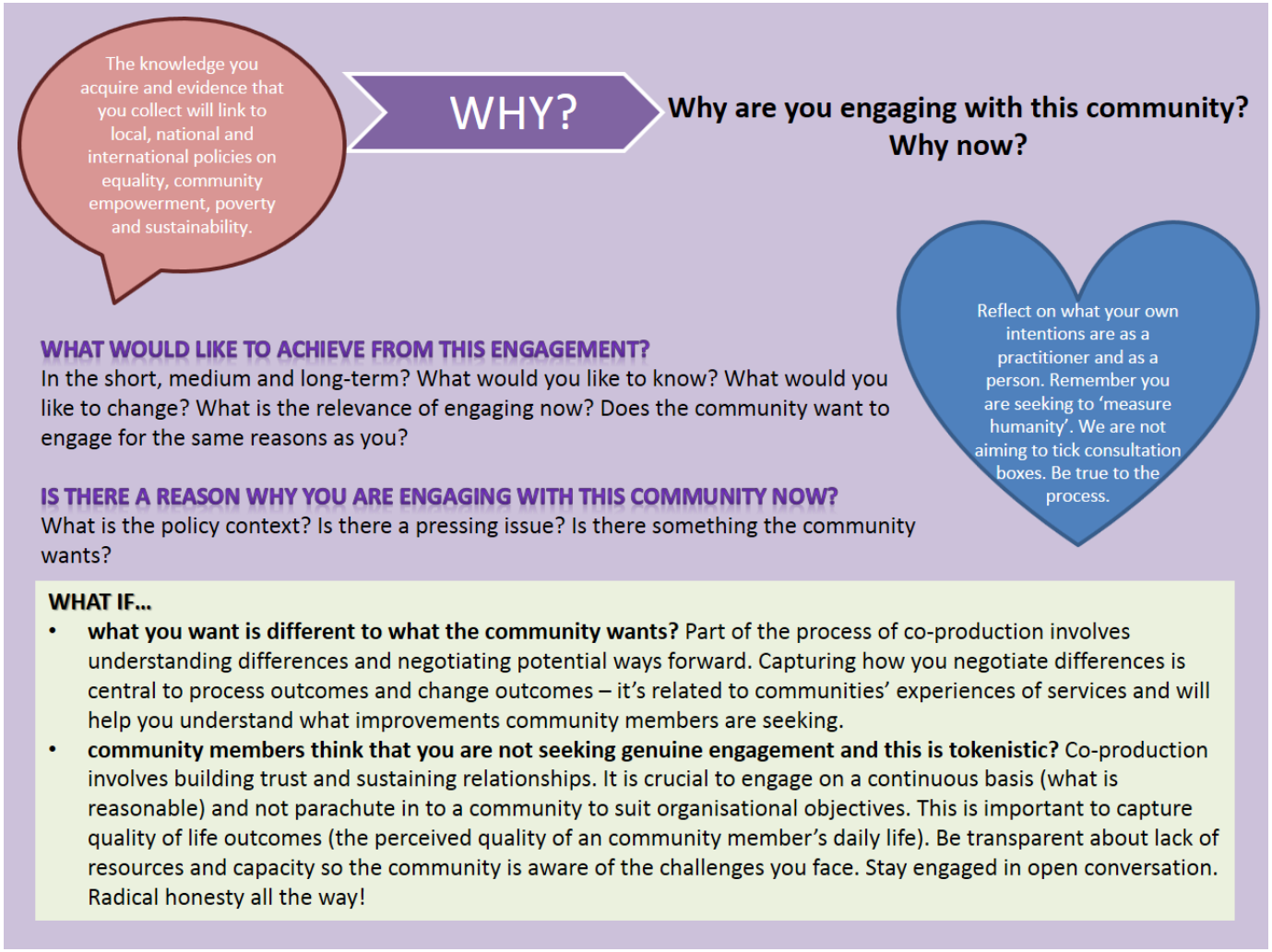


The second level of application of ABIF is called "Process". It is recommended that the Process happens before the actual engagement with the community and to serve as baseline for the further co-production of ABIF.

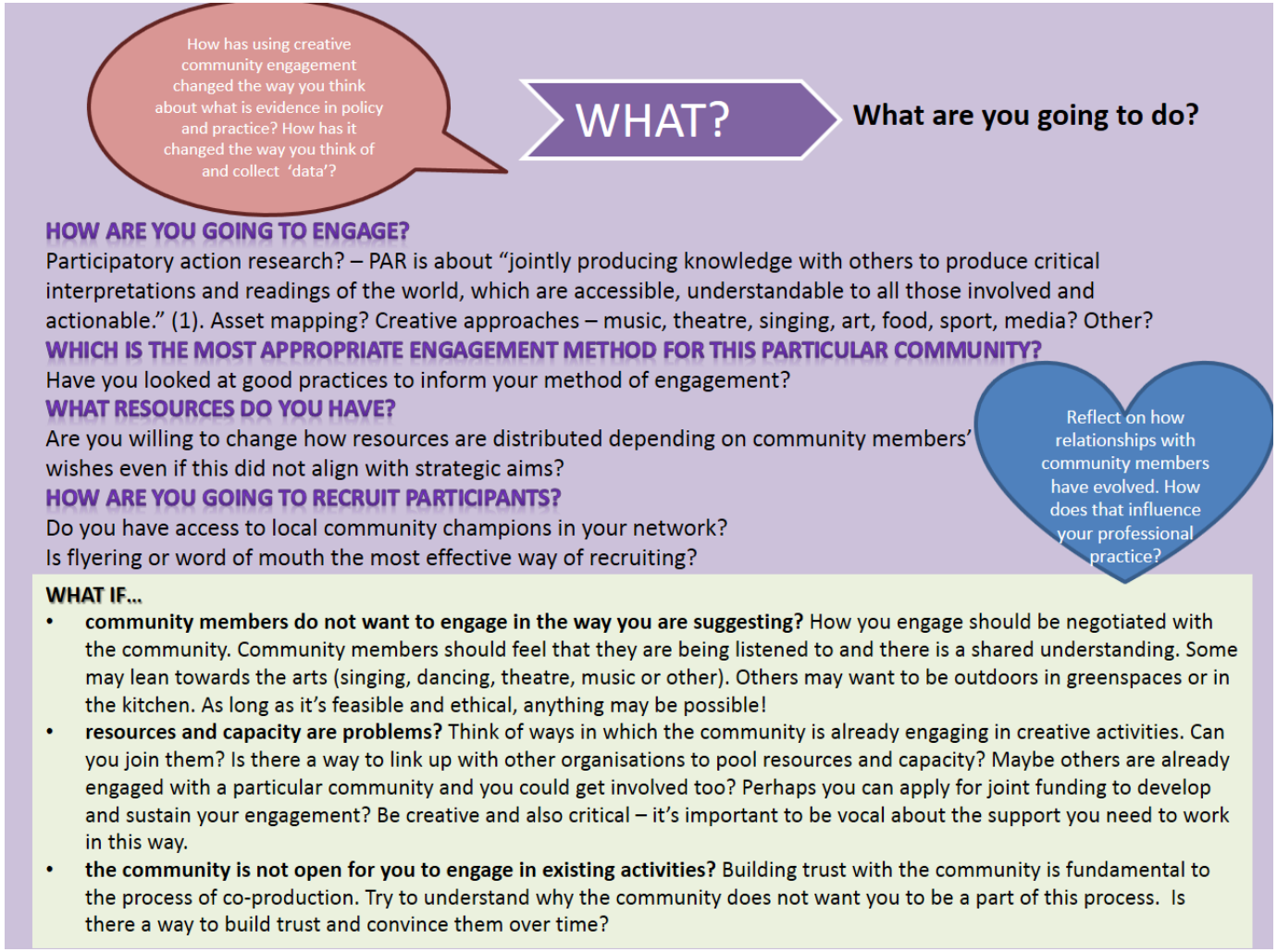
Step 1: WHO?



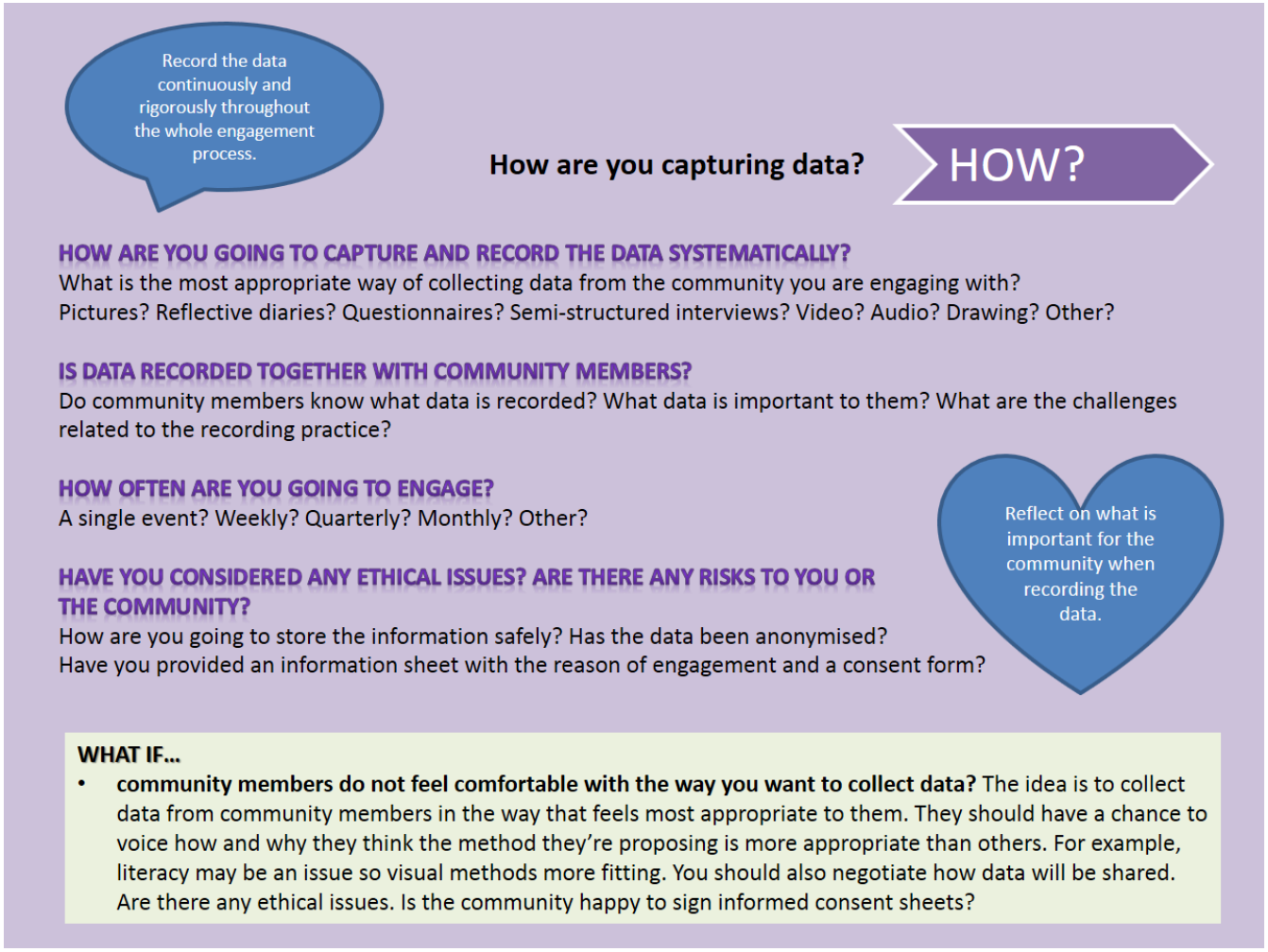
Step 2: WHY?


The knowledge you acquire and evidence that you collect will link to local, national and international policies on equality, community empowerment, poverty and sustainability.
WHY?
Why are you engaging with this community? Why now?
Reflect on what your own intentions are as a practitioner and as a person. Remember you are seeking to 'measure humanity'. We are not aiming to tick consultation boxes. Be true to the process.
WHAT WOULD LIKE TO ACHIEVE FROM THIS ENGAGEMENT?
In the short, medium and long-term? What would you like to know? What would you like to change? What is the relevance of engaging now? Does the community want to engage for the same reasons as you?
IS THERE A REASON WHY YOU ARE ENGAGING WITH THIS COMMUNITY NOW?
What is the policy context? Is there a pressing issue? Is there something the community wants?
WHAT IF...
• what you want is different to what the community wants? Part of the process of co-production involves understanding differences and negotiating potential ways forward. Capturing how you negotiate differences is central to process outcomes and change outcomes – it's related to communities' experiences of services and will help you understand what improvements community members are seeking.
• community members think that you are not seeking genuine engagement and this is tokenistic? Co-production involves building trust and sustaining relationships. It is crucial to engage on a continuous basis (what is reasonable) and not parachute in to a community to suit organisational objectives. This is important to capture quality of life outcomes (the perceived quality of an community member's daily life). Be transparent about lack of resources and capacity so the community is aware of the challenges you face. Stay engaged in open conversation. Radical honesty all the way!

Step 3: WHAT


How has using creative community engagement changed the way you think about what is evidence in policy and practice? How has it changed the way you think of and collect 'data'?
WHAT?
What are you going to do?
HOW ARE YOU GOING TO ENGAGE?
Participatory action research? – PAR is about "jointly producing knowledge with others to produce critical interpretations and readings of the world, which are accessible, understandable to all those involved and actionable." (1). Asset mapping? Creative approaches – music, theatre, singing, art, food, sport, media? Other?
WHICH IS THE MOST APPROPRIATE ENGAGEMENT METHOD FOR THIS PARTICULAR COMMUNITY?
Have you looked at good practices to inform your method of engagement?
WHAT RESOURCES DO YOU HAVE?
Are you willing to change how resources are distributed depending on community members' wishes even if this did not align with strategic aims?
HOW ARE YOU GOING TO RECRUIT PARTICIPANTS?
Do you have access to local community champions in your network?
Is flyering or word of mouth the most effective way of recruiting?
Reflect on how relationships with community members have evolved. How does that influence your professional practice?
WHAT IF...
• community members do not want to engage in the way you are suggesting? How you engage should be negotiated with the community. Community members should feel that they are being listened to and there is a shared understanding. Some may lean towards the arts (singing, dancing, theatre, music or other). Others may want to be outdoors in greenspaces or in the kitchen. As long as it's feasible and ethical, anything may be possible!
• resources and capacity are problems? Think of ways in which the community is already engaging in creative activities. Can you join them? Is there a way to link up with other organisations to pool resources and capacity? Maybe others are already engaged with a particular community and you could get involved too? Perhaps you can apply for joint funding to develop and sustain your engagement? Be creative and also critical – it's important to be vocal about the support you need to work in this way.
• the community is not open for you to engage in existing activities? Building trust with the community is fundamental to the process of co-production. Try to understand why the community does not want you to be a part of this process. Is there a way to build trust and convince them over time?

Step 4. HOW?


Record the data continuously and rigorously throughout the whole engagement process.
How are you capturing data?
HOW?
HOW ARE YOU GOING TO CAPTURE AND RECORD THE DATA SYSTEMATICALLY?
What is the most appropriate way of collecting data from the community you are engaging with?
Pictures? Reflective diaries? Questionnaires? Semi-structured interviews? Video? Audio? Drawing? Other?
IS DATA RECORDED TOGETHER WITH COMMUNITY MEMBERS?
Do community members know what data is recorded? What data is important to them? What are the challenges related to the recording practice?
HOW OFTEN ARE YOU GOING TO ENGAGE?
A single event? Weekly? Quarterly? Monthly? Other?
Reflect on what is important for the community when recording the data.
HAVE YOU CONSIDERED ANY ETHICAL ISSUES? ARE THERE ANY RISKS TO YOU OR THE COMMUNITY?
How are you going to store the information safely? Has the data been anonymised?
Have you provided an information sheet with the reason of engagement and a consent form?
WHAT IF...
• community members do not feel comfortable with the way you want to collect data? The idea is to collect data from community members in the way that feels most appropriate to them. They should have a chance to voice how and why they think the method they're proposing is more appropriate than others. For example, literacy may be an issue so visual methods more fitting. You should also negotiate how data will be shared. Are there any ethical issues. Is the community happy to sign informed consent sheets?

The third level of application is to define the indicators important to the community.

The ABIF Template is offered as a tool to be applied at the start of the creative community engagement. It helps us agree on definitions for indicators so we know what these indicators mean to particular communities at the start. It also allows is to capture baseline data.
Indicators need to be "measured" at the start of a community engagement, throughout the engagement process and at the "end" of a co-produced initiative (if there is one). This allows us to capture changes that communities want to see.

Through the process of co-production, it may be possible to identify ways to illustrate how and why changes are occurring (or not occurring) while asset-based initiatives are being implemented.

Professionals can use the discussion guide to prompt discussions around the ABIF if appropriate. Flexibility in using the guide is recommended. Professionals should take into consideration group and discussion dynamics. It is ok not to ask all questions, or to include new questions. This should be recorded.

Table 5

Indicator	Happiness	Access to Resources	Healthy Environment	Culture	Empathy	Helpfulness	Social Connectedness	Optimism	Physical Health	Self-determination	Spirituality	Personal Meaning	Trust
Definition													
Individual level													
Community level													
Structural level													

1. Introduction to ABIF	• Provide each participant with a copy of the template. If you are working in a big group split participants into small groups. Introduce the indicators from the table gradually so that participants have the time to look at each indicator.
2. Rate these indicators in order of importance to you [1 through….].	• Ask community members to rate each indicator individually in order of importance to them. Ask the group to discuss how they rated the indicators. Ask the group to come to a consensus on the order of indicators.
3. Define each indicator in simple terms	• After rating the indicators, ask community members to define the indicators in simple terms. The definition is then discussed in the group and any differences are identified.
4. Come to a consensus about the order of importance of indicators	• Ask community members to come to a consensus on the order of importance of indicators as a group.
5. How would you practically 'do' these indicators?	• Ask participants about the practical implications of their 'most important' indicators. For example, "How would you show someone you empathise with them?" Then ask participants to discuss this in the group on individual, community and structural levels.
6. In which indicators would you like to see change?	• Ask community members to identify the indicators in which they want to experience change.
7. What would you like to do to experience change?	• Ask participants what they would like to do (what type of engagement) to experience a change in the identified indicators.

When applying the mechanism consider following points:

Step 1. Apply the ABIF template

WHAT IF…

- **community members are illiterate?** Ask community members how they would prefer to discuss or capture information. Do they want to draw, sing or act instead? Filming? Audio? Other means of data capturing?

Step 2. Ask community members to rate these indicators in order of importance to them

WHAT IF…

- **community members ask whether they should rate the indicators from an individual or community perspective?** Encourage community members to think about their preference and leave the choice to them. Your role is to note the choice they have made and to understand why they have made it.

- **there are significant differences in the rating between individuals?** Discuss this in the group and determine how it might impact the process of prioritising the aims of the engagement.

Step 3. Ask community members to individually define indicators

WHAT IF…

- **community members can't make sense of all indicators?** Community members might wish not to include some of the indicators if they are not meaningful to them and this is ok. If they want you to give them a definition of the 'unclear' indicators you can refer to the *Table with indicators' definitions.*

community members want to add a new indicator? Remember that it is about what makes sense to community in their everyday lives. You can be as flexible as you need to be in adding 'new' indicators that are meaningful for the community.

Step 4. Ask the group to come to a consensus about the order of importance of indicators

Observe how the group comes to a consensus. Are there 'leaders' in the group? Are there 'observers'? What is the group dynamics? What are the group relationships? How might these relationships impact the process of engagement? Are group members open to learning together, exploring together and working to achieve goals together? Are differences between definitions 'resolved'? How?

WHAT IF…

- **the group doesn't come to a consensus?** Note down why community members disagree and reflect on how this might impact the engagement process.

Step 5. Ask community members how they would practically do each of the indicators important to them

WHAT IF…

- **the group isn't sure what you mean?** Think of some practical examples that make sense to you. How would you show somebody that you empathise with them?

STEP 6. Ask community members which indicators they most want to see change in? How do they want to see these changes?

WHAT IF…

- **the group wants different things?** See if you can reach a consensus through skilful negotiation. Capacity and resourcing may be an issue so ask the group if there's anything they can all agree on.

Step 7. Ask community members what they want to do to experience change in the indicators?

WHAT IF…

- **the group isn't sure how they get involved?** Facilitate a discussion on how they can be agents of change. Signpost them to existing services or initiatives in the area.

The fourth level of application of ABIF is the identification of the outcomes professionals and community members want to achieve.

OUTCOMES

Consider the meaning of outcomes for community members and their own views of what they want to achieve.

WHAT ARE THE DIFFERENT OUTCOMES THAT YOU NEED TO IDENTIFY?

Have you considered capturing process, change and quality of life outcomes?

Process outcomes are related to community's experiences of using a service.
Change outcomes refer to the improvements that community members are seeking.
Quality of life outcomes include features of a person's whole life that they are working towards achieving or maintaining in partnership with services and other forms of support.

Have you considered capturing short-term, medium- term and long-term outcomes?

Reflect on the process of change by keeping a reflective diary. If change is not happening reflect on 'why' it isn't.

WHAT IS THE ENDPOINT THAT YOU WANT TO REACH THROUGH THE ENGAGEMENT?

Consider what activities and processes would be required to achieve it.

HOW DOES YOUR ENGAGEMENT WORK?

What is the process by which change comes for this particular community?

WHAT IF...

- **Community members do not agree with the outcomes you want to achieve?** Your role is to understand what outcomes individuals want to achieve and what support they would need to achieve these outcomes.
- **Community members show resistance or a disbelief that change can happen?** Listen, acknowledge feelings, respond empathetically and encourage support. If you accept people's response, they will continue to tell you how they are feeling. This will help you respond to some of their concerns.
- **Change does not happen?** The process of co-production is flexible. Your methods of working might need to be adjusted as the engagement progresses. This is a crucial feature in asset-based working.

The fifth and final level suggests that the identified outcomes should be aligned to local, national, and international policies or action plans.

Link these outcomes to local, national and international policies or action plans as illustrated here.

Outcome level	Focus	Example
Individual	Defined by the person as what is important to them.	I want to be able to freely access services.
Local	Defined by the local authority as key area to work towards.	Barriers to HSCP services are removed for people with relevant protected characteristics (Glasgow HSCP Equality Outcomes).
National	Defined by government to focus activity across sectors and organisations.	Our public services are high quality, continually improving, efficient and responsive to local people's needs (National Performance Framework, Scottish Government).
International	Defined by international bodies such as the World Health Organization	Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all (Sustainable Development Goals, United Nations).

9. Overall Summary

This report presented the development and first application of an evidence-based, co-produced methodological framework – an Asset-Based Indicator Framework (ABIF). The first part of the report presented the findings of a critical literature review which served as a base for the development of the ABIF.

The first stage of the review identified the *three, key overlapping concepts* related to asset-based working – wellbeing, social capital and resilience. Evidence suggested that these concepts theoretically describe different phenomena, but upon closer inspection, are interrelated and influenced by the same or similar individual, community and structural assets. A further refined review of the literature was conducted and determined that there are overlaps between definitions of single factors and assets impacting the three concepts. This further analysis established the perimeters of framework indicators and outlined outlined 10 main assets, which serve as ABIF indicators. Each indicator was defined and its impact on individual, community and structural levels were presented.

The second stage of the review looked at the evidence for the evaluation of asset-based approaches. General recommendations guided the further development of ABIF as an evaluation tool. The review then presented evidence about the main methods used to evaluate asset-based approaches- personal outcomes, theory of change and logical modelling.

The report presented the process of development and piloting the co-produced ABIF with Roma communities living in Soutside Glasgow. Finally, the report included a guide for the co-production of ABIF with recommendations for practitioners and researchers.

Epilogue

When we first developed the ABIF framework we recognised that it can not be a prescriptive mechanism for measuring change in community work as it is entirely designed around the concept of co-production (see p. 58). Findings from the PAR workshops with professionals showed that the framework should be used in a 'non-deterministic way' to allow for a "real community development process" to take place (see p.71, 82). What further became evident after applying the framework with Roma community members was that some of the indicators did not make sense to them (such as 'affect') or that they had to be devided into two categories (such as spirituality and personal meaning). We, therefore, updated the table with ABIF indicators (see below).

The current report serves as an illustration of the approach we took to develop and apply the ABIF framework for the first time. The described ABIF application process, however, is not intended to be prescriptive but should be applied with the respective flexibility that a meaningful engagment with communties might require.

Indicator	Definition	Individual Level	Community Level	Structural Level
Happiness	Veenhoven (1995) defined happiness or life satisfaction as the degree to which one judges the quality of one's life favourably (p.34). Initially, the extended literature review identified 'affect' as an indicator impacting health and wellbeing. However, here we are referring to happiness because it is a more familiar term than affect. Affect is defined as the experience of positive or negative emotions at a certain point in time (OECD 2013).	Individuals experience high average levels of positive affect which benefits their interpersonal relationships, creativity, sociability, and productivity. Individuals are able to restore autonomic (unconscious or involuntary responses) responses after the experience of adverse negative affect.	Communities live happy and healthy lives driven by success and thriving.	Individuals and communities respond to detrimental occurrences in the macro environment influencing their health and wellbeing (for example, human rights).
Access to resources	Resources that people need access to for their livelihoods.	Individuals have access to organisations; this provides them with opportunities to access different forms of social capital (the norms, social networks and trust in a community, which contribute to pursuing mutual objectives (Harper 2001; Putnam 2001).	Communities provide opportunities for individuals to access different organisations and social structures.	The state ensures that socio-economic distribution of neighbourhood resources is equal for each community. Co-production between local and external organisations.
Healthy environments	Physical, social and service environments of neighborhoods which promote health (Cubbin et al. 2008).	Individuals have access to health promoting amenities and resources which enable them to maintain healthy lives.	Communities have established health promoting amnesties and resources.	The state ensures that cities are healthy places for communities to live in.

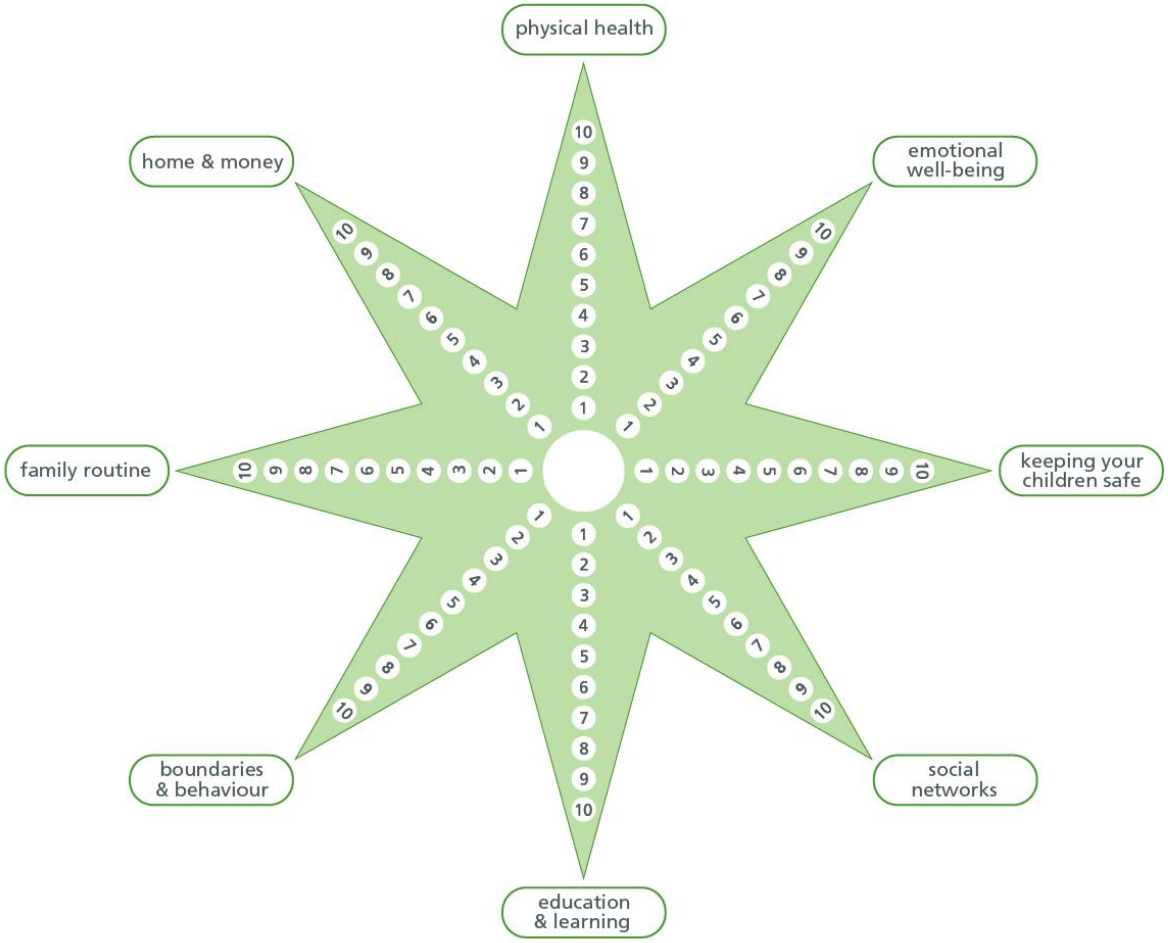
Culture	Knowledge, beliefs, values and systems of symbolic meaning that individuals draw on in everyday life (Spencer-Oatey, 2012).	Individuals have a sense of identity and culture. Individuals are free to express and live according to their cultural values and norms. Individuals have the freedom of religious expression.	Communities create opportunities for recreation, physical activity, self-expression of individuals. Communities create opportunities for celebration of cultural values. Communities provide an opportunity for individuals to celebrate difference.	Individuals and communities feel free to exercise their culture in an environment that encourages equity and respect for human rights.
Empathy	Empathy reflects an innate ability to perceive and be sensitive to the emotional states of others coupled with a motivation to care for their wellbeing (Decety, 2015).	Individuals are able to understand the perspective of others	Community members are interdependent, experiencing high levels of empathy.	An understanding that various factors impact on the ability to empathise: motivational forces (eg. need to belong); situational cues (eg. attraction); individual or group differences (eg. gender, ethnicity); education level; self-monitoring; culture; and relationship-specific factors (Sherman et al 2015).
Helpfulness	Positive attitude and willingness to help others.	Individuals have positive attitudes to helping others.	Community members experience high levels of helpfulness.	There is a good understanding about what contextual and structural factors influence the levels of helpfulness in different communities and cultures.

Interpersonal relationships	Interpersonal relationships can be: - Bonding (based upon strong ties that connect homogeneous groups). - Bridging capital (between people who are from different ethnic or occupational backgrounds). - Linking (between people with different levels of power and status).	Individuals are able to benefit from functional aspects of interpersonal relationships such as emotional support, companionship or advice in experiences of adverse stress. Individuals are socially connected in a way that a change in behavior in one is likely to produce a change in behavior of the other. Individuals are involved in community activities which contribute to the improvement of their health and wellbeing.	Communities recognise the principles of equalities and social justice. Difference within and outside of the community group are acknowledged and accepted. Communities provide widespread opportunities for informal contacts and support networks. Community organisations work with wider networks to mutual advantage. Communities are socially connected which contributes to the improvement of their health and wellbeing.	Different community groups, forums, and organisations participate in the voluntary health sector and provide valuable source of experience and innovation for national legislation. Efforts to address inequalities.
Optimism	Expectations about the occurrence of good outcomes in one's future (Pinquart, Fröhlich, & Silbereisen, 2007).	Individuals have positive expectations about their future. Individuals engage in efforts towards desired goals.	Communities provide positive opportunities for people's future.	New opportunities are created and potential influence for improvements.
Physical Health	The functioning of your body	Individuals lead healthy lives.	Communities have a	Physical health of the

	as it is designed to function.	Individuals are able to have optimal levels of wellbeing	high percentage of physically healthy individuals.	population has improved. People live healthier and long lives.
Self-determination	Psychological construct which refers to the internal motivation of the self to behave in an autonomous and controlled way.	Individuals experience greater autonomy in their everyday life. Individuals are able to express their individuality and self-identity. Individuals are able to regulate their behaviour in congruence to their values and needs. Individuals are able to make informed decisions about participating in support services which will best meet their needs and improve their health and wellbeing. Individuals are able to maintain their independence as they get older and are able to access appropriate support when they need it.	Communities are aware of their needs, as well as assets. Communities are able to make informed choices about their political, social, and cultural development in order to create healthier neighbourhoods.	Local communities participate actively in public affairs and decision making on a national level in regards to the delivery of health services and interventions.
Spirituality	The quality to strive for meaning and purpose by believing in a spiritual dimension.	Individuals construct their own spirituality which help them cope with stressful and threatening situations.	Communities encourage individuals to express their spirituality, as well as provide an environment where they can be developed.	People are contributing to societal change through their different spirituality.

Personal Meaning	The striving to answer infinite questions when facing emotional difficulties, stress, illness or death.	Individuals have a purpose in life which is determined by their personal meaning and values.	Communities encourage individuals to express their personal meaning.	People are contributing to societal change through their different meanings of life.
Trust	Trustworthiness experienced in a reciprocal relationship. Forms of trust: - in close interpersonal relationships (such as family and close friends); - social connectedness with the wider community or members of the outside community.	Individuals are trusting. Individuals are able to build different social relationships.	Communities have high levels of trust and co-operative norms.	Society is safe from crime, disorder and danger.

Appendix 1



Family Star™ (2nd Edition) © Triangle Consulting Social Enterprise Ltd
Authors: Sara Burns and Joy MacKeith
www.outcomesstar.org.uk

Appendix 2 Phase 1: literature review to inform evidence-based ABIF

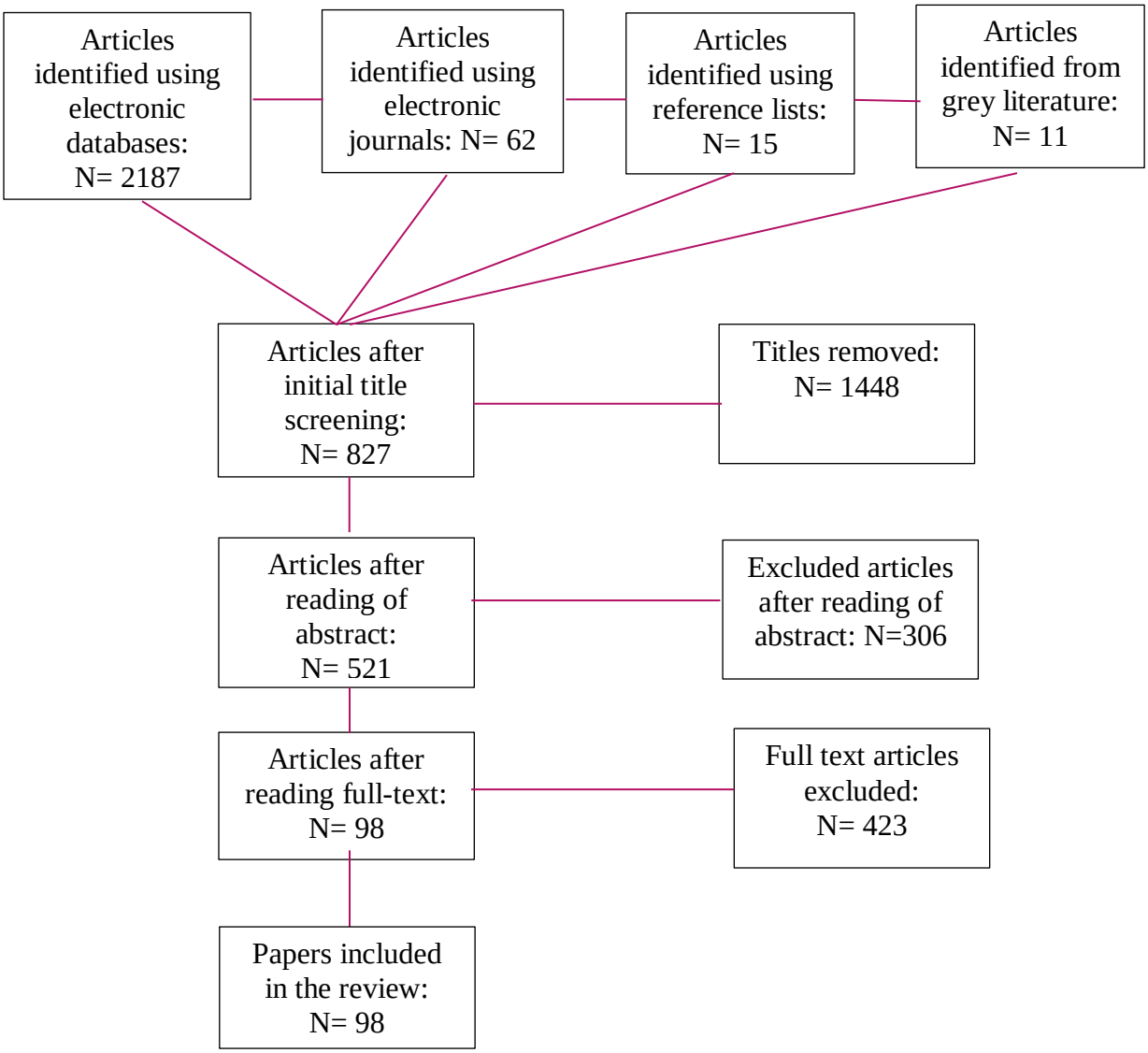
Search terms

The search strategies used in the literature review were divided into two categories. The first category referred to the use of terms related to evaluation of asset-based approaches and included following search strings:

- 'asset-based approach*' AND ('effectiveness' OR 'evaluation' OR 'measurement')
- 'asset-based approach*' AND ('health' OR 'wellbeing') AND evaluation
- 'co-production' AND ('effectiveness' OR 'evaluation' OR 'measurement')
- 'co-production' AND ('health' OR 'wellbeing') AND evaluation

The other search strategies, which were used to identify relevant literature to inform indicators, were following:

- 'wellbeing' AND 'measurement' AND 'public health'
- 'social capital' AND ('measurement' AND 'public health') OR ('wellbeing')
- 'resilience' AND ('measurement' AND 'public health') OR ('wellbeing')
- 'self-determination' AND ('health' AND 'wellbeing') OR ('measurement')
- 'trust' AND ('health' AND 'wellbeing') OR ('measurement')
- 'affect' AND ('health' AND 'wellbeing') OR ('measurement')
- 'interpersonal relationships' AND ('health' AND 'wellbeing') OR ('measurement')
- 'self-esteem' AND ('health' AND 'wellbeing') OR ('measurement')
- 'social coherence' AND ('health' AND 'wellbeing') OR ('measurement')
- 'culture' AND 'public health'
- 'empathy' AND ('health' AND 'wellbeing') OR ('measurement')
- 'spirituality' AND ('health' AND 'wellbeing') OR ('measurement')
- 'optimism' AND ('health' AND 'wellbeing') OR ('measurement')
- 'access to resources' AND ('health' AND 'wellbeing') OR ('measurement')
- 'physical health' AND ('health' AND 'wellbeing') OR ('measurement')



Notes

- If professionals work with individual and community assets instead of focusing on societal needs, they will deliver services that will improve wellbeing, social capital, and resilience of communities.

- Identify assets contributing to the reduction of health inequalities to inform indicators for an evaluation framework.
- 3 primary concepts related to asset-based working: wellbeing, social capital, and resilience - describe different phenomena, but when explored in depth they appear to be interrelated and influenced by the same or similar individual, community, and structural assets. The mechanisms of their relationship would play a significant role in the evaluation of asset-based approaches.
- For example, an individual's wellbeing is influenced by the levels of social capital in a society. Individual's participation in social networks has been positively associated with life satisfaction and enjoyment of life. Resilience was found to impact wellbeing through personal characteristics of individuals, values and beliefs of communities, as well as interpersonal relationships with family, friends and community.
- Assets identified by the literature review are categorised in the table below to see to what extent they overlap. (Table 1 and 2 from the literature review were presented).

Appendix 3. Participant Information Sheet

Research about Community Strengths, Health and Wellbeing

You are being invited to take part in a research project for the University of Edinburgh funded by NHS Greater Glasgow & Clyde: Public Health Directorate and South Sector Health Improvement Team. Before you decide whether or not to take part, it is important for you to understand why this research is being conducted and what it will involve. Please take time to read the following information carefully. Contact us if there is anything that is not clear or if you would like more information.

What is the research?
The current workshop is part of the project "An Asset-Based Indicator Framework: using co-production, co-design and innovative methods to engage with BME groups in Glasgow's South Side". The main project aim is to involve you, other community members, people working for government and the health service, and different organisations in the design and delivery of services such as health.

We want to know what's important to you. For example, what does it mean for you to be 'healthy' and 'well'? How can health services be better for you? How would you explain things like trust to other people? How would you know if you felt trusted? How would others know that you trust them?

Why have I been asked to take part?
Your thoughts, ideas and opinions are very important to our project. If we didn't speak to you about these things, we'd have to guess about what's important to you. We want to understand what matters to you when it comes to being healthy and well and use this information to help us make changes to the way we offer health services. We also want you to play an equal part in making services better for you.

What will happen if I take part?
You will join others in your community and a researcher in a guided discussion about your health and wellbeing. You may also part in a one-day 'singing' workshop together with other community members and people outside of the community from the health service.

Our discussions and singing exercises will be focused on understanding each other better especially when it comes to your health. In the singing workshop, you will get to write a song (together with other community members and people working in health) to share your opinions and views about what is important to you and your community. More information will be given if you decide to take part.

Are there issues of confidentiality?
Information from this research will be used in academic publications, reports, presentations and other communications. Your name will **not** be shared in any written publications. Nobody will know that

the opinions you share came directly from you – they will just know that it came from someone in your community.

We will also be filming the discussions and singing workshop. This is to help us understand more about your ideas, thoughts and opinions. We want to use these films, recordings, pictures and other materials in our work to help other people understand what is important to you. If you agree, these materials will be shared with other people on a website. This means others will be able to see videos or pictures of you. If you do not wish to be video-recorded or audio-recorded, you will not be able to participate in this research.

Do I have to take part?
You can choose if you want to take part or not. We will give you all the information you need before you decided if you want to be a part of this project. If you do, you will sign a form agreeing to take part.

You are free to leave at any time and don't have to tell us why. If you leave after the workshop has taken place and you have been filmed, you may still be included in the video of the workshop as it may not be possible to completely remove you from the group work. The information you gave during the discussion will not be included in any documents.

Are there any benefits to participation?
You will receive a £20 voucher that you can spend on anything that you may need or want.

You will also get the chance to tell people who work for the health services what it is that you would like to see changed or improved.

If you have any further questions please contact Dr Marisa de Andrade on 0131 651 5554 or email: marisa.deandrade@ed.ac.uk

Concerns or complaints can be raised with Prof Charlotte Clarke, Head of School, on 0131 650 4327 or email: Charlotte.Clarke@ed.ac.uk

The complaints form is available here: http://www.ed.ac.uk/university-secretary-group/complaint-handling-procedure/procedure

Thank you for taking the time to read this information sheet.

CONSENT FORM
Research about Community Strengths, Health and Wellbeing

Participant contact details: _____

Please initial box

1. I confirm that I have read and understand the information sheet (as specified in this document header) for the above study and have had the opportunity to consider the information and ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. I understand that if I choose to withdraw, any information I have given will be removed from any published reports or other written documents. However, I understand that, as the discussions and singing workshops will be video-recorded and audio-recorded, it will not be possible to remove my image or words from these recordings and they will still be publically available, as described in the information leaflet. ☐

3. I understand that the research will be used in academic publications, reports, presentations and other communications including online. ☐

4. I understand that if data is generated that can be used for research and knowledge exchange purposes, my contributions may be used but they will remain anonymous and my identity will not be disclosed. ☐

5. I would like my community to be named as a partner in the co-production process, which is part of this research. If so, the community may be named in subsequent academic publications, reports, presentations and other communications including online. ☐

6. I understand that the 'singing' workshop will be filmed, audio- recorded or photographed for the purposes of the research and I agree to this. ☐

7. I agree for the video, audio, photographs or other materials to be publically available on a website, designed for the purposes of the research. ☐

8. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature

_____	_____	_____
Name of Person taking consent	Date	Signature

Appendix 4. Participant Information Sheet

An Asset-Based Indicator Framework: using co-production, co-design and innovative methods to engage with BME groups in Glasgow's South Side

You are being invited to take part in a research project for the University of Edinburgh funded by NHS Greater Glasgow & Clyde. Before you decide whether or not to take part, it is important for you to understand why this research is being conducted and what it will involve. Please take time to read the following information carefully. Contact us if there is anything that is not clear or if you would like more information.

What is the research?
The project aims at co-designing and co-producing an Asset-Based Indicator Framework (ABIF) to monitor and evaluate asset-based approaches. The current stage of the project is a 'singing' workshop.

Why have I been asked to take part?
Your involvement and expertise in this field has been recognised and we welcome the opportunity for you to help us co-produce this framework.

Your participation in Phase 1 of the ABIF project was identified as invaluable to the development of the framework and, therefore, we are inviting you to participate in Phase 2 which is the delivery of a 'singing' workshop.

Do I have to take part?
Participation is voluntary. You will be given this information sheet to keep and be asked to sign a consent form.

You are free to withdraw at any time and without giving a reason. If you leave after the workshop has taken place and you have been filmed, you may still be included in the video of the workshop as it may not be possible to completely remove you from the group work. The information you gave during the discussion will not be included in any documents.

What will happen if I take part?
You will take part in a 'singing' workshop in which you will be able to collaborate with Roma community members in the co-production of the framework. Further clarification will be given if you decide to take part. The singing workshop will be filmed to provide a further level of analysis and allow for knowledge exchange.

Are there issues of confidentiality?
Data generated from this research will be used in academic publications, reports, presentations and other communications. The research interest is not in individual details but in the overall theoretical and practical contribution to the development of the ABIF. Therefore, your identity will **not** be disclosed in any written publications – all your contributions will be anonymised.

There is an option below for you to tick if you would like your organisation to be named as a partner in the co-production process.

We are also using videos, podcasts and other images/materials on a publically available digital portal called Measuring Humanity. It will serve as an online community of practice for practitioners, policymakers and community members using co-production and asset-based approaches. If you agree, materials generated from this research will be made available on this portal. If you do not wish to be video-recorded or audio-recorded, you will not be able to participate in this research.

If you have any further questions please contact Dr Marisa de Andrade on 0131 651 5554 or email: marisa.deandrade@ed.ac.uk

Concerns or complaints can be raised with Prof Charlotte Clarke, Head of School, on 0131 650 4327 or email: Charlotte.Clarke@ed.ac.uk

The complaints form is available here: http://www.ed.ac.uk/university-secretary-group/complaint-handling-procedure/procedure

Thank you for taking the time to read this information sheet.

CONSENT FORM
An Asset-Based Indicator Framework: using co-production, co-design and innovative methods to engage with BME groups in Glasgow's South Side

Participant contact details: _____
_____

Please initial box

1. I confirm that I have read and understand the information sheet (as specified in this document header) for the above study and have had the opportunity to consider the information and ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. I understand that if I choose to withdraw, any information I have given will be removed from any published reports or other written documents. However, I understand that, as the discussions and singing workshops will be video-recorded and audio-recorded, it will not be possible to remove my image or words from these recordings and they will still be publically available, as described in the information leaflet. ☐

3. I understand that the research will be used in academic publications, reports, presentations and other communications including online. ☐

4. I understand that if data is generated that can be used for research and knowledge exchange purposes, my contributions may be used but they will remain anonymous and my identity will not be disclosed. ☐

5. I would like my organisation to be named as a partner in the co-production process, which is part of this research. If so, the organisation may be named in subsequent academic publications, reports, presentations and other communications including online. ☐

6. I understand that the 'singing' workshop will be filmed, audio recorded or photographed for the purposes of the research and I agree to this. ☐

7. I agree for the video, audio, photographs or other materials to be publically available on a website, designed for the purposes of the research. ☐

8. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

Appendix 5. Singing Workshop Evaluation Form

An Asset-Based Indicator Framework: using co-production, co-design and innovative methods to engage with BME groups in Glasgow's South Side

Date: 4/12/2016

As a participant in the singing workshop your feedback is very important to the successful co-production of the ABIF framework. Please take a few minutes to tell us about your experience.

1. **What did you learn about community's perceptions of health and wellbeing after participating in the workshop?**

2. **What does this tell you about ways to evaluate health and wellbeing of communities?**

3. **What is your own perception about health and wellbeing and did it change (how?) after your participation in the workshop?**

4. **What would you do next time when you engage with communities?**

5. **Other comments**

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